

13234

## CERTIFICATE OF DEATH

13246

1. DECEASED-NAME (Type or print) <b>Nicholas Francis Ray</b>			2a. DATE OF DEATH <b>9</b> Month <b>12</b> Day <b>68</b> Year			2b. HOUR <b>7</b> P.M.			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>3-<del>19</del>6-1881</b>		6. AGE (In years lost birthday) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONT. CO.</b>			
10. CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Kensington Gardens</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3503 Anderson Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Nicholas A. Ray</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret C. Briggs</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-14-2894</b>		17. INFORMANT <b>Thurston Ray</b>		Address <b>Kensington Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>433.9</b> IMMEDIATE CAUSE (a) <b>MASSIVE STROKE THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cerebrovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Years</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>332.2 CONGESTIVE Heart Failure</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/12</b> , 19 <b>65</b> , to <b>9/12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>9/12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>CHARLES FARWELL</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9/17/68</b>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>WHEATON/CHATELAIN</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept. 15, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor</b>		23d. LOCATION (City or Town) (County) (State) <b>Etchison Mont. Md.</b>			
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1881

Station House, No.

1881, 1882, 1883

SEP 1 1888

1881, 1882, 1883

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VR A15 (4)  
30M REV. 1/68

13235		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				13247	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
ALLEN		EDWARD	REED		9 13 68		11:40p
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
male	white		5-15-02		66 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.
ohio	USA				Montgomery		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park		Washington San & Hosp		legislative analysis			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
D.C.		Washington				3343 Quesada St. NW	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	
Robert		Della		no			
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Ventricular Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Arteriosclerosis</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
wife Mrs. Sharon Reed Washington, D.C.		Address 3343 Quesada St. NW		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		21g. STREET OR R.F.D. No.		21h. CITY OR TOWN	
21i. LOCATION		21j. STREET OR R.F.D. No.		21k. CITY OR TOWN		21l. STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1967</u> to <u>Sept 14 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 14 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Benjamin Manchester</u>		22c. DATE SIGNED <u>9/14/68</u>		22d. PHYSICIAN'S NAME (Type) <u>Benjamin Manchester</u>	
22e. ADDRESS <u>106 Irving St. N.W. Washington, DC</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/17/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>		24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>SEP 17 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
13236											
13248											
1. DECEASED-NAME (Type or print) <i>Hattie</i>			First <i>Jane</i>			Middle <i>Reed</i>			Last		
2a. DATE OF DEATH			Month <i>Sept.</i>			Day <i>1st</i>			Year <i>1968</i>		
2b. HOUR			9 <sup>55</sup> A M								
3. SEX <i>F.</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>July 22 - 1889</i>			6. AGE (In years last birthday) <i>79</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Olney, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Bronck Lane Foundation</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Cash House</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Bethesda</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <i>John</i> Middle <i>Edward</i> Last <i>Dimsey</i>			15. MOTHER'S MAIDEN NAME First <i>SARAH</i> Middle <i>M.</i> Last <i>GREEN</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>578-20-5136</i>		
17. INFORMANT <i>Jane Reed, R.N.</i>			Address <i>Brooke-Grove Foundation - Medical Files</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Pneumonia</i>										<i>4 days</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Active selection caused under disease</i>										<i>20 yrs.</i>	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>Sept 1, 1968</i> to <i>Sept 1, 1968</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>Sept 1, 1968</i> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.											
22b. SIGNATURE <i>A.D. Bonifant</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <i>9/1/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>A.D. BONIFANT</i>										22e. ADDRESS <i>Sandy Springs, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>										23b. DATE <i>9/4/68</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem. Arlington, Virginia.</i>										23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>										25a. REC'D BY REGISTRAR <i>SEP 10 1968</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											

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13237												13249																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH												CERTIFICATE OF DEATH																							
1. DECEASED-NAME (Type or print)						First Middle Last						2a. DATE OF DEATH						2b. HOUR																	
S.						John						REISMAN						Sept. Month Day 10 Year 68 1247 M																	
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (In years lost birthday)				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN.															
Male				Caucasian				Aug. 26, 1905				63 YRS.																							
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH																							
New York				USA								Montgomery				Md.																			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY																							
Bethesda				Naval Hospital				Physician				Medicine																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER																			
Maryland				Montgomery				Bethesda								7916 Deepwell Drive																			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																													
First Middle Last						First Middle Last																													
John						Reisman						Anna						Schein																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)						16b. SOCIAL SECURITY NO.						17. INFORMANT						Address																	
Yes						129-30-0788						Mrs Anna Reisman																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART I. DEATH WAS CAUSED BY:																																			
IMMEDIATE CAUSE (a)												Cardiac Arrest																							
4109												DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Myocardial Infarction																							
												(b)																							
												DUE TO, OR AS A CONSEQUENCE OF																							
												(c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																			
4201																																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																											
22a. I certify that (X) (this hospital) attended the deceased from Sept 9, 1968, to Sept 10, 1968, that (X) (we) last saw the deceased alive on Sept 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE												22c. DATE SIGNED																							
S. FRANK DOVI LT MC USNR												Sept. 10, 1968																							
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS																							
												Naval Hospital, Bethesda, Md.																							
23a. BURIAL, CREMATION, REBURY (Type)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)																							
Burial				9/12/68				Union Field Cemetery				Queens Co. N. Y.																							
24. FUNERAL DIRECTOR Danzanski & Sons ADDRESS												25a. REC'D BY REGISTRAR DATE												25b. REGISTRAR'S SIGNATURE											
3501 14th Street, N.W., Washington, D. C.												SEP 16 1968												Charles Judge											

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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH				2b. HOUR						
Peter				JOHN		REKLIS		SEPT 27 Day Year 68				1205 M								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.						
Male			Caucasian			June 29, 1891			17 YRS.											
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH											
Pennsylvania			USA						Montgomery Md.											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY											
Bethesda			Naval Hospital			U. S. Navy			N.O.S.											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER								
Maryland			CHARLES			Indianhead			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			25 Potomac Avenue								
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																
First Middle Last				First Middle Last																
Matthew				Recklis				CHRISTINE				STEPULAVICUS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address								
yes				1910-1917				220-32-6710				Mr. Peter T. Recklis, 249 Lomond Dr.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY:																				
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma with Liver, Heart and</u>																				
1991 DUE TO, OR AS A CONSEQUENCE OF Kidney Disease																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																				
(b) DUE TO, OR AS A CONSEQUENCE OF																				
(c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
1992																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
			19																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that <del>the</del> (this hospital) attended the deceased from <u>Sept. 13</u> , 19 <u>68</u> , to <u>Sept. 27</u> , 19 <u>68</u> , that <del>it</del> (we) lost saw the deceased alive on <u>Sept. 27</u> , 19 <u>68</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) <del>did not</del> view the body after death.																				
22b. SIGNATURE <u>James N. Trone</u>													DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
																	Sept. 27, 1968			
22d. PHYSICIAN'S NAME (Type)													22e. ADDRESS							
JAMES N. TRONE, CDR MC USN													Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)											
Burial			10-1-1968			Arlington National			Arlington, Virginia											
24. FUNERAL DIRECTOR													25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hunt Funeral Home													DATE OCT 3 1968		Charles Judge					
Waldorf, Maryland																				



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EXHIBIT OF BLANK

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RECEIVED  
OCT 3 1938  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

OCT 3 1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (10-68)  
30M REV. 11-68

13239 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13251	
Item#23a, FilmG405 10/7/68 km										CERTIFICATE OF DEATH	
1. DECEASED-NAME (Type or print) <b>NED</b>			First <b>JEFFREY</b> Middle <b>JEFFREY</b> Last <b>RENN</b>			2a. DATE OF DEATH <b>9-29-68</b> Month <b>9</b> Day <b>29</b> Year <b>68</b>			2b. HOUR <b>3 A M</b>		
3. SEX <b>male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>3-5-03</b>			6. AGE (In years lost birthday) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>PA. PW. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASH. SAN. HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>DISABLE</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. CITY OR TOWN <b>PRINCE GA.</b>		13c. CITY OR TOWN <b>HYATTS.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8114 14th AVE.</b>		
14. FATHER'S NAME First <b>EDWARD</b> Middle <b>Franklin</b> Last <b>RENN</b>			15. MOTHER'S MAIDEN NAME First <b>Alice</b> Middle <b>ADELIA</b> Last <b>GRANT BORING</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>232-05-7476</b>		17. INFORMANT <b>hosp RECORD</b> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 year</b> <b>years</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4200</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>-</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , 19 <b>68</b> , to <b>Sep 29</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>9/26</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Norman H. Rubenstein</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>9/29/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Norman H. Rubenstein, MD</b>						22e. ADDRESS <b>11161 New Hamp. Ave. Sil. Sp., Md</b>					
23a. BURIAL, CREMATION, BURIAL (Specify)			23b. DATE <b>Oct 2, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bayard Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Grant Co. W. Va</b>			
24. FUNERAL DIRECTOR <b>J. M. Jackson</b>			ADDRESS <b>Falls Church Va</b>			25a. REC'D BY REGISTRAR DATE <b>OCT 2 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR						
OSCAR							REZNICK		Sept. Month 20 Day 1968		120 P.M.						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR						
MALE			WHITE			April 1880			88 YRS.		MONTHS DAYS HOURS MIN.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			25. HOUR					
POLAND			USA						Montgomery			Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
Silver Spring, Md.			411 HANNES ST.			GROCER											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER						
MARYLAND			MONTGOMERY			SILVER SPR.					411 Hannes St., S.S., Md.						
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First		Middle		Last	
YESHAYOHU							REZNICK		LEAH								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address								
NO						SON-IN-LAW			SILVER SPR. MD.								
						ABRAHAM JACOBS - 411 - HANNES ST.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) 1541 Terminal Carcinomatosis										11 mos.							
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) Invasive rectal carcinoma		12 mos.					
DUE TO, OR AS A CONSEQUENCE OF										(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
1541																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
			HOUR A.M. Month Day Year P.M. 19														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Sept 16, 1967, to Sept 20, 1968, that (I) (we) last saw the deceased alive on Sept 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (saw) view the body after death.																	
22b. SIGNATURE										22c. DATE SIGNED							
Donald W. Datlow, M.D.										9-20-68							
22d. PHYSICIAN'S NAME (Type) Dr. Donald Datlow										22e. ADDRESS							
										823 University Blvd., W.S.S., Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)								
BURIAL			9-22-68			NATIONAL CAPITAL HEBREW			WASHINGTON DC								
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
BERNARD DANZANSKY			950 N. WASH. DC			DATE SEP 26 1968			J. Charles Judge								





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13241

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13253

1. DECEASED-NAME (Type or Print) <b>JANE Kathleen RIEMER</b>			20. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> <b>Sept 14</b> 1968			2b. HOUR <b>1:42</b> M				
3. SEX <b>FEMALE</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>June 27 1921</b>		6. AGE (In years last birthday) <b>47</b> YRS.		7. COUNTRY OF BIRTH <b>USA</b>		
7a. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Mail Telegraphic</b>		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Secretary</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Mail Telegraphic</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Montgomery</b> COUNTY <b>Chesapeake</b>			13b. CITY OR TOWN <b>Chesapeake</b>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>3508 Preston Court</b>	
14. FATHER'S NAME First <b>Cornelius</b> Middle <b>Spencer</b> Last <b>?</b>			15. MOTHER'S MAIDEN NAME First <b>Kathleen</b> Middle <b>?</b> Last <b>?</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Son</b> ADDRESS <b>Same as Item 13</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide Inhalation -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Smoke Inhalation from house fire -</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>890X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION <b>9/16/68</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <b>9/14/68</b> HOUR A.M. <b>1:30</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Smoke inhalation from house fire</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>			21f. LOCATION Street or R.F.D. No. <b>3508 Preston Court</b> City or Town <b>Chesapeake</b> County <b>Montgomery</b> State <b>Md</b>				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>John G. Ball</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>Sept 14, 1968</b>				
EXAMINER'S NAME (Type) <b>John G Ball</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
			ADDRESS (Street, city, town, or county) <b>Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Type) <b>Cremation</b>			23b. DATE <b>9-16-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland Pr. Geo. Md</b>	
24. FUNERAL DIRECTOR <b>Robert A Pumphrey</b>			ADDRESS <b>7557 Wisconsin Ave Bethesda, Md</b>			25a. REC'D BY REGISTRAR <b>SEP 23 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

13253

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13253



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219 23 1968  
John W. Hill  
2-16-68  
219 23 1968  
John W. Hill  
2-16-68

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13242

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13254

1. DECEASED-NAME (Type or Print) <b>KARL</b>			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>Sept 14 1968</b>			2b. HOUR <b>6:50 AM</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>July 14, 1905</b>		6. AGE (in years last birthday) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>LIEPZIG GERMANY</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.		
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUBURBAN</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>ATTORNEY</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>LAW</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>			13c. CITY OR TOWN <b>CHEVY CHASE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>3508 PRESTON COURT</b>			14. FATHER'S NAME First Middle Last <b>Guido Carl RIEMER</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Grier</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>579-52-2696</b>			17. INFORMANT <b>Son</b>			ADDRESS <b>Same as Item 13.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Burns - extensive 3rd degree - 90% body</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>House fire</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>890X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7hr.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>9160</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>13th 9/14 1968</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Burned in house fire</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>				21f. LOCATION Street or R.F.D. No. City or Town County State <b>3508 Prescott Court Chevy Chase Montgomery Md.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John G. Ball</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>Sept. 14, 1968</b>			
EXAMINER'S NAME (Type) <b>John G Ball</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS <b>Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md</b>				25a. REC'D BY REGISTRAR <b>SEP 23 1968</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE <b>9-16-68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			
23d. LOCATION (City or Town) <b>Suitland Pr.</b>				23e. LOCATION (County) <b>Geo.</b>				23f. LOCATION (State) <b>Md</b>			

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328, 45, 978

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	
Arnold			(NMN)		Rivkin		September 19 1968		2b. HOUR P. 4:40 M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)	
Male			White			26 May 1919			49 YRS.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH	
New York			USA						Montgomery Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center, NIH			Economist			US Gov't.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	
Washington, D.C.			Washington, DC			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Samuel Rivkin			Ethel Dubin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT				
Yes			1942-45			Bethesda, Maryland 20014				
			052-14-2783			The Medical Records, The Clinical Center,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Pulmonary emboli										
DUE TO, OR AS A CONSEQUENCE OF										
(b) Venous thrombosis of left leg										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Lymphosarcoma										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
2001										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from 16 July, 1968, to 19 Sept., 1968, that (X) (we) last saw the deceased alive on 19 September 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (did not) view the body after death.										
22b. SIGNATURE								22c. DATE SIGNED		
Michael B. Mosher, M. D.								20 September 1968		
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS		
Michael B. Mosher, M. D.								The Clinical Center, National Institutes of Health, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Removal			9-21-1968					Hempstead, Long Island, N.Y.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Joseph Cawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016						DATE SEP 26 1968		J Charles Judge		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
30M REV. 1/68

13244				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				13256			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		Month Day Year		2b. HOUR		M	
Nathan		Marmaduke		Roberts		9 7 68		5:45		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Caucasian		8/12/1904		64 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Ohio		USA				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Wheaton		University Nursing Home		Executive director							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		413 Twinbrook Pkwy.			
14. FATHER'S NAME		First Middle Last		15. MOTHER'S MAIDEN NAME		First Middle Last					
Alvadore Roberts		(don't know middle name)		Hannah Hornady							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
no		292-01-4784		Mildred L. Roberts		413 Twinbrook Pkwy					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Carotid Aneurysm</u>										2 hrs	
5901 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sepsis</u>										2 ds	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Art. Pyelonephritis</u>										7 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
6000 <u>dissection Cerebral Artery</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Jan 1964, to Sept 1968, that (I) (we) last saw the deceased alive on Sept 5 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type)		William Killay, M. D.		22e. ADDRESS		8218 Wisconsin Ave., Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		9-12-68		Memorial Park		Vandalia Ohio					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert A Pumphrey		7557 Wisconsin Ave Bethesda, Md		DATE SEP 11 1968		J Charles Judge					

13556

10200



RECEIVED THE DIRECTOR OF THE BUREAU OF THE ARMY

SEP 11 1968

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13245

13257

1. DECEASED-NAME (Type or print) Alice H. ROBERTSON			2a. DATE OF DEATH September 27, 1968		2b. HOUR 5:43PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH October 18, 1919		6. AGE (In years last birthday) 48 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Montgomery County, Md.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital, Bethesda	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Disbursing specialist	12b. KIND OF BUSINESS OR INDUSTRY State Dept.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia	13b. COUNTY Blackstone	13c. CITY OR TOWN Blackstone	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 308 Dinwiddie Ave.	
14. FATHER'S NAME First Middle Last Zebulon V. ROBERTSON	15. MOTHER'S MAIDEN NAME First Middle Last Alice G. JOHNSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No	16b. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Irvin J. ROBERTSON 4008 Hanover Av., Richmond, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5670 Multiple intra-abdominal abscesses with fistulae DUE TO, OR AS A CONSEQUENCE OF (b) Probable septicemia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 576x					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from December 20, 1967, to September 27, 1968, that (X) (we) last saw the deceased alive on September 27, 1968, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. D. Bell M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED September 28, 1968
22d. PHYSICIAN'S NAME (Type) J. D. BELL					22e. ADDRESS Naval Hospital, Bethesda, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Sept 30, 1968	23c. NAME OF CEMETERY OR CREMATORY Richmond, Virginia	23d. LOCATION (City or Town) (County) (State) Richmond, Virginia		
24. FUNERAL DIRECTOR Joseph Gawler & Sons, Washington, D. C.		25a. REC'D BY REGISTRAR DATE OCT 2 1968	25b. REGISTRAR'S SIGNATURE Charles Judge		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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4-11  
Cleared Medical Examiner Dr. Belmont  
2222

13246

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13258

1. DECEASED-NAME (Type or print) First Middle Last <i>Nancy (nmn) Rothacker</i>			2a. DATE OF DEATH Month Day Year <i>9 5 68</i>			2b. HOUR <i>11:30 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>6-7-95</i>		6. AGE (In years last birthday) YRS. MONTHS DAYS <i>73</i>	
7a. BIRTHPLACE (State or foreign country) <i>Georgia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. Sant Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>ANNE ARUNDEL</i>		13c. CITY OR TOWN <i>Annapolis</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>Willis Elmore</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Sarah Edwards</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Hospital Record</i>		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Admitted pulmonary embolism</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>58771</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Generalized atherosclerosis, Hypertension</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>9-1-68</i> , to <i>9-5-68</i> , that (I) (we) last saw the deceased alive on <i>5-5-68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Fidel J. Quintana</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>9-5-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>FIDEL J. QUINTANA</i>				22e. ADDRESS <i>8725 1st Ave, S. S Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-7-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR <i>Joseph Cawley's Sons, Inc., N.W., Wash., D.C., 20016</i>				ADDRESS <i>5130 Wisc. Ave.</i>		25a. REC'D BY REGISTRAR <i>SEP 9 1968</i>	
				25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			



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90  
Cleared & Medical Examiner John Bellard 15  
Pfeifferman md.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
Virginia E ROWE					Month	Day	Year	12 <sup>15</sup> PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female	White		10-1-1882		85 YRS.		MONTHS	DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Wheaton		Wheaton Nursing Home 11901 Georgia Ave.		Housewife		Own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Silver Spring				8830 Piney Branch Road	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Robert		Henry	Hunter		Mary		Frances	Nowlan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no		578-16-8090		Stuart Mitchell		4623 Jalstone Ave. Ch. Ch. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cerebrovascular accident - (thrombosis)								2 days.	
DUE TO, OR AS A CONSEQUENCE OF									
(b) Arteriosclerotic vascular disease								years.	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
3322X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from Feb- 1968, to Sept 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
JAMES R COLEMAN						Sept 17, 1968			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
JAMES R COLEMAN		9241 COLUMBIA BLVD		SILVER SPRING, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		9-19-1968		George Washington Cem.		Prince Georges Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
C. Glen Carter		Sil. Spr., Md.		SEP 20 1968		Charles Judge			
Warner E. Pumphrey, Inc. 8434 Georgia Avenue									

03551

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201, 13260									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>RITA</b>			First Middle Last			2a. DATE OF DEATH <b>Sept. Month 11 Day 68 Year</b>			2b. HOUR <b>3:15 PM</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 7, 1887</b>			6. AGE (In years last birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Charles Co., md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Rockville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Potomac Valley Hsg. Home - Potomac Valley Rd.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>MONTG.</b>		13c. CITY OR TOWN <b>Kenwood</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5207 Norway Drive</b>
14. FATHER'S NAME First Middle Last <b>GEORGE - CARPENTER</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ALBERTA TILDA HUNT</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>E.R. ROWZEE-SON - ONTARIO, CANADA</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA, BILATERAL</b> <b>4339</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRAL THROMBOSIS, RT. HEMIPLEGIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIO SCLEROSIS, GENERAL</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 wk.</b> <b>5 mo.</b> <b>2 yr.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>332X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE</b> , 1967, to <b>SEPT</b> , 1967, that (I) (we) last saw the deceased alive on <b>SEPT. 11</b> , 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Leo M. Curtis MD.</b> DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>9-11-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>LEO M. CURTIS, M.D.</b>					22e. ADDRESS <b>8218 WISCONSIN AVE., BETHESDA, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>9-13-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>BLADENSBURG, P.G., MD.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>JOSEPH GAULERS SONS, 5130 WIS. AVE., N.W. WASH., D.C.</b>					25a. FILED BY REGISTRAR DATE <b>SEP 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



13260

13260

13260

Rowlee 247-11 6-34

ATA

May 7, 1951

White

Female

Montgomery

Chas Co, and. W.S.A.

Home - 13260

Rockville

2521 Highway Drive

Remond

Marland

13260

13260

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 7/68

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Joseph J. Rudigier					Sept 26 1968			4 <sup>00</sup> PM	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
male	white	11/9/95			72				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Baltimore, Md.	U.S.A.			Montgomery Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring		Holy Cross			machinist				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Md.		Montgomery	Sil. Spr.		YES	215 Franklin Avenue			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
<del>Spokane</del> Joseph Rudigier					Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, not or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
yes		215-26-0294		Mrs. Florence B. Rudigier		Sil. Spr., Md. 215 Franklin Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-Abdominal Abscess</u> <u>569.4</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gastro-Cutaneous Fistula</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Perforation Transverse Colon</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>578X</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
8-20-68		LUQ Abd. Abscess			YES		YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <u>8-10</u> , 19 <u>68</u> , to <u>9-26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9-25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>Ira Miller, M.D.</u>								9-27-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Ira Miller, M.D.				8218 Wisconsin Ave. Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		9-28-1968		Gate of Heaven Cemetery		Sil. Spr.		Montg.	Md.
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Warner E. Pumphrey, Inc.				Maryland 8434 Ga. Ave. Sil. Spr.		DATE OCT 2 1968		J. Charles Judge	

13249

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13261

1992

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 10. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13250

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13262

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year			2b. HOUR		
Jesse Willard Saunders						9-9 1968			11:59A		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
Male	White	8-13-1915	53 YRS.					9 Day 9 Year 19 68			11:59A
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
West Virginia		U.S.A.				Montgomery					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Pk.			Wash San & Hosp.			Guard			Wheaton Plaza		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland			Montgomery		Kensington			2911 Faulkner Pl			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Alex Saunders			Minnie B Rankins								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
No			235-09-9856		Martha A. Saunders 2911 Faulkner Place			Kensington, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Coronary insufficiency, acute DUE TO, OR AS A CONSEQUENCE OF (b) Coronary sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden Years Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Pneumoconiosis - chronic											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			Belden R. Reap M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Sept. 9, 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City and town) (County) (State)			
Burial			9-12-68		St. Lincoln Cemetery			Prince Georges Md.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
E. Glen Carter			SEP 16 1968			J. Charles Judge					

13885

STATE OF TEXAS

13885

STATE OF TEXAS

1911-12

SEP 10 1988



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH																										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																										
13251						13263																				
1. DECEASED-NAME (Type or print)						First			Middle			Last			2a. DATE OF DEATH			2b. HOUR								
Baby						Boy			Schriber			Month 9 Day 4 Year '68			1:40 PM											
3. SEX						male			4. RACE			colored			5. DATE OF BIRTH			6. AGE (in years lost birthday)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (State or foreign country)						Maryland			7b. CITIZEN OF WHAT COUNTRY?			U.S.A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
10. CITY OR TOWN OF DEATH						Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			Suburban Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						Maryland			13b. COUNTY			Montgomery			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER					
14. FATHER'S NAME						First			Middle			Last			15. MOTHER'S MAIDEN NAME			First			Middle			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)						(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address											
William Stone						Schriber			Nancy Lee			Hyson			Mather - 1310 Wheaton Lane			Wheaton								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY:																										
IMMEDIATE CAUSE (a) Prematurity																										
777X DUE TO, OR AS A CONSEQUENCE OF																										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												(b)														
DUE TO, OR AS A CONSEQUENCE OF												(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																										
776X																										
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																										
22b. SIGNATURE												22c. DATE SIGNED														
Dr. Melha																										
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS														
Dr. Melha																										
23a. BURIAL (CREMATION, REMOVAL) (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City or Town) (County) (State)								
9/6/68						Suburban Hospital						Bethesda-Montg. Md.														
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Mrs. Amelia C. Carter, Administrator												DATE SEP 10 1968			John Charles Judge											

13363

13363

RECEIVED

RECEIVED

RECEIVED

SEP 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13252										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13264																																																											
1. DECEASED NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																																																	
ROLAND										EDGAR SEIDEL, SR.										SEPT.										20 1968										5:10 A M																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.																													
MALE										WHITE										JAN. 9, 1889										79 YRS.										MONTHS										DAYS										HOURS										MIN									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																																																	
BALTIMORE MD										USA																				MONTGOMERY										Md.																																							
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
SILVER SPRING										EPICLAND NURSING HOME										CARPENTER																																																											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																																							
MARYLAND										BALTIMORE										BALTIMORE										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										2719 FENWICK																																							
14. FATHER'S NAME										First Middle Last										15. MOTHER'S MAIDEN NAME										First Middle Last																																																	
FRANCIS										A SEIDEL										MARY										DEWILIN																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																																																	
No										(If yes give war or dates of service)										215-09-0973A Roland E Seidel Jr.										1005 Maple Ave Laurel Md																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF																																																	
410.9																				acute myocardial infarction										Thrs.																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										arteriosclerotic Heart Disease										4RS.																																																	
(c)																																																																															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																																															
Uremia, Severe Iron Deficiency anemia, Herpes ophthalmicus																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																											
22a. I certify that (I) (this hospital) attended the deceased from 7/11, 1968, to 9/20, 1968, that (I) (we) last saw the deceased alive on 9/19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																															
22b. SIGNATURE										DEGREE										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED																																																	
R.T. BENACK MD																														9/20/68																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																																					
R.T. BENACK MD										4115 Colie DR. Wheaton, MD																																																																					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																																																	
Burial										9/23/68										Parkwood										Baltimore, Md																																																	
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																	
Leonard J Ruck Inc.										Baltimore, Maryland										SEP. 24 1968										Charles Judge																																																	

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REVENUE OF INDIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Dr. Page 68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
13253					13265					
1. DECEASED-NAME (Type or print) <b>Margaret E. Sheehan</b>					2a. DATE OF DEATH Month <b>September</b> Day <b>1</b> Year <b>1968</b>			2b. HOUR <b>7:30</b> A.M.		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 5, 1913</b>			6. AGE (In years lost birthday) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS <b>55</b> DAYS <b>55</b>	
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery, Md.</b>				
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House-wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>9534 Clement Rd.</b>	
14. FATHER'S NAME First <b>David</b> Middle <b>J.</b> Last <b>Williams</b>			15. MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>Jones</b> Last <b>Jones</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or, unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>278-09-1042</b>		17. INFORMANT Address <b>William E. Sheehan 9534 Clement Rd. S.S. Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs</b> <b>3 yrs</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>										
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , to <b>Aug 31, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 31, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John Lawrence Avery MD</b> DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>Sept 1, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>John Lawrence Avery, MD.</b>					22e. ADDRESS <b>10620 Georgia Ave., Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>9-4-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ht. Lincoln Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladensburg Pr. Geo. Md.</b>				
24. FUNERAL DIRECTOR <b>M. Andrew Dwall</b> ADDRESS <b>Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md.</b>					25a. REC'D BY REGISTRAR DATE <b>SEP 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



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## CERTIFICATE OF DEATH

13254

13266

1. DECEASED NAME (Type or print) <b>MARY E. Sheehan</b>			2a. DATE OF DEATH Month <b>Sept</b> Day <b>23</b> Year <b>1968</b>			2b. HOUR <b>3:25</b> M	
3. SEX <b>Female</b>		4. RACE <b>W.</b>		5. DATE OF BIRTH <b>July 14 - 1883</b>		6. AGE (In years last birthday) <b>85</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Randolph Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>none</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Cherry Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>Terimach Sheehan</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Healy</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <b>215-54-6897-7</b>		17. INFORMANT <b>Neice Mary Louise Quigley</b>		Address Same as Item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> <b>486x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>493x Cardiac arteriosclerosis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>5/36</b> , 19 <b>47</b> , to <b>9/23</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>9/14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (we) view the body after death.							
22b. SIGNATURE <b>William E. Gentry</b>		DEGREE <b>WILLIAM E. GENTRY</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9-23-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>WILLIAM E. GENTRY</b>		22e. ADDRESS <b>Washington D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>9-25-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

13886

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

13255  
13267  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4900 Cumberland Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>Bell</b> Middle <b>C. Shepard</b> Last		4. DATE OF DEATH <b>September 5</b> 19 <b>68</b> Month <b>September</b> Day <b>5</b> Year <b>1968</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1888</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR: Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Joseph Churchyard</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Thompson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-46-8270</b>	
17. INFORMANT <b>Daughter</b> Address <b>Same as Item 2.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 4109 DUE TO (b) <b>Arterio Sclerotic Heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4201</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 12, 1964</b> to <b>Sept 4, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept 4, 1968</b> , and that death occurred at <b>10:30</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Peyton R. Evans Jr</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>PEYTON R. EVANS JR</b>		22d. ADDRESS <b>5401 Western Ave Wash DC 20015</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>9-7-68</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>SEP 11 1968</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/50

13256		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				13268	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last RIVA Sharpnick		2a. DATE OF DEATH Month Day Year 9 3 68				2b. HOUR 10 <sup>40</sup> AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 5-11-1901		6. AGE (In years lost birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) POLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN LANHAM		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last ISAAC VARGAR		15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN		13e. STREET AND NUMBER 7111 LEMPTON ROAD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 214-48-6019T		17. INFORMANT Address SIMON SIKKES SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy with atherosclerosis</u> 1530 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1530							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from January 1960, to Sept 3, 1968, that (I) (we) lost saw the deceased alive on Sept 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE BLAINE H. EIG		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/3/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 9401 Bergshire Drive, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9-5-1968		23c. NAME OF CEMETERY OR CREMATORY GEO. WASH. CEM		23d. LOCATION (City or Town) (County) (State) HYATTSVILLE P.G. MD.	
24. FUNERAL DIRECTOR Goldberg Funeral Home		ADDRESS 4217 9th St. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR DATE SEP 6 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Campanula medium

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BRINE HERRING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13257		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		13269	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print)		First	Middle	Lost	20. DATE OF DEATH
Mykola			Shramchenko		9 Month 26 Day 68 Year 258 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7. IF UNDER 1 YEAR
Male	White	24 April 1909		59 YRS.	MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Ukraine	U.S.A.		Montgomery Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring		Holy Cross Hosp.		ARTIST	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
			Washington D.C.		1119 Buchanan St. N.W.
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME
Ivan Shramchenko					Unknown
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address	
NO		579-44-3661		Eugene Shramchenko same as 13 e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage					
4309 DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 330X (b) Hypertensive cerebrovascular					
DUE TO, OR AS A CONSEQUENCE OF (c) Disease.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
Portal Cirrhosis & Hepatic insufficiency					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 9/30, 19 68, to 9/30, 19 68, that (I) (we) last saw the deceased alive on 9/30/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
M.W. Shapiro					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS	
M.W. Shapiro				8107 Eastern Ave. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		9/30/68		Rock Creek Cemetery Washington, D.C.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	
THE S.H. HINNESS CO		2901 14TH ST. N.W. WASH. D.C.		DATE SEP 30 1968	
				25b. REGISTRAR'S SIGNATURE	
				Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
13258						13270									
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR						
LILLIAN			NMN			SILVER			Month 9 Day 27 Year 68 8:15 AM						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
F		W		6-7-91			77 YRS.		MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
RUSSIA			U.S.A.						MONTGOMERY			Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
TAKOMA PARK			WASH. SAN. Hosp												
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
MD			P.C.			TAKOMA PARK			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1200 12th Street Avenue			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
ABRAHAM			ROSENFELD			HENRIETTA									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address						
No			08-22-2749			DAUGHTER-IN-LAW			TAKOMA C. MD.			10010 NEWHALL RD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Pulmonary insufficiency												4 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 450X															
(b) Pulmonary embolism												8 days			
DUE TO, OR AS A CONSEQUENCE OF															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
Pulmonary Cerebral Infarction															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
			HOUR A.M. Month Day Year P.M. 19												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from April 1964, to April 27, 1967, that (I) (we) last saw the deceased alive on April 27, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE												22c. DATE SIGNED			
JAMES M. WHITLOCK												9-27-68			
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS			
JAMES M. WHITLOCK												2217 Cornell Ave Takoma Park Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			9-30-68			WASH NATH CEMETERY			SUITLAND MD						
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.W. Chambers Co Silver Spring Md												DATE OCT 3 1968		J Charles Judge	





15 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13259										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13271																																							
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																													
Gertrude (NMN) Silverman																				September 5, 1968										1:10 M																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS.									
Female										White										September 17, 1996										71 YRS.										MONTHS DAYS HOURS MIN.																			
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
Maryland										America																				Montgomery																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Takoma Park										Washington Sanitarium										retired; Teacher										Education																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
Maryland										Prince George										Greenbelt										YES										9001 Breezewood Drive																			
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																	
Isaac Paul										Lithuania Jennie Sindler																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
no										215-44-4356										Patient's chart																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										Carcinoma of Breast & Metastases										6 mo.																													
153.9										DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										DUE TO, OR AS A CONSEQUENCE OF																																							
										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
153.9																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from										1957 Sept 5, 1968, that (I) (we) lost										saw the deceased alive on Sept 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the										causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE										James Whitaker, M.D.										22c. DATE SIGNED										Sept 5, 1968																													
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS										7717 Greenbelt Ave Takoma Park Washington																																							
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										9-6-1968										Arl. National Cemetery										Arlington, Va.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Goldberg Funeral Home										4217 5th St. N.W. Wash. D.C.										DATE SEP 6 1968										Charles Judge																													

13271

CRIMINAL RECORD

13271

September 2, 1958 1:10

Clinton

(M)

Female

September 11, 1958

White

Female

Temporary

X

Married

Married

Education

High School

Washington State

High School

3001 Greenwood Drive

Clinton, Washington

Clinton

Clinton

Female

Clinton

Male

Male

Clinton, Washington

no

Clinton, Washington

Clinton, Washington

Clinton, Washington

SEP 6 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and coroner, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
13260						13272							
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR				
First Middle Last Lawrence Spencer SIMCOX						Month 14 Day 68 Year SEP			6:43A				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)				
Male			Caucasion			12 OCT 1910			57 YRS.				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
TENN.			U.S.						MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
BETHESDA			Naval Hospital			U.S. ARMY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
MD.			MONTGOMERY			Kensington			7916 Carriage Road				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last John Thomas SIMCOX			First Middle Last Mabel Spencer										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) - (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
YES WW II			412-16-1759			THOMAS SIMCOX			9716 Carriage Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <del>MY MYOCARDIAL INFARCTION WITH CARDIAC ARREST</del>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
4201													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 8 SEP, 19 68, to 14 SEP, 19 68, that (I) (we) lost saw the deceased alive on 14 SEP, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE C. S. REEVES										22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) C. S. REEVES, M.D.										22e. ADDRESS			
										Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
17 SEP 1968			17 SEP 1968			ARLINGTON			ARLINGTON VIRGINIA				
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Charles F. Thompson										DATE SEP 17 1968		J. Charles Judge	

13275

THOMAS SINGO

13275



CHIEF OF BUREAU

NAME

THOMAS SINGO

13275

UNIT

U.S.

ARMY

POSTAL

ARMY

ARMY

NO.

THOMAS SINGO

ARMY

NAME

THOMAS SINGO

ARMY

NO.

13275

THOMAS SINGO

THOMAS SINGO

THOMAS SINGO

SEP 1 1963



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

13261		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 5 Film G404 8/17/68		13273	
1. DECEASED-NAME (Type or print) First Middle Last Mary Ellen Simmons			2a. DATE OF DEATH Month Day Year September 12, 1968		2b. HOUR 8:30 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH 1880 October 1887		6. AGE (In years lost birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5814 Greenlawn Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Store Employee	12b. KIND OF BUSINESS OR INDUSTRY Dress Shop	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5814 Greenlawn Drive	
14. FATHER'S NAME First Middle Last Samuel E. Martin		15. MOTHER'S MAIDEN NAME First Middle Last Mary Cockrel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 578-09-4758	17. INFORMANT Address Mrs. Hetty Martin-Niece-same item # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from April 1965, to Sept 12, 1968, that (I) (we) last saw the deceased alive on June 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lewis N. Cahill M.D.		22c. DATE SIGNED September 12, 1968		22d. PHYSICIAN'S NAME (Type) Lewis N. Cahill	
22e. ADDRESS 5411 Cedar Lane, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 9/14/68	23c. NAME OF CEMETERY OR CREMATORY Rock Creek		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Tyson Wheeler - 1331 Rockville Pike Rockville, Maryland		25a. REC'D BY REGISTRAR DATE SEP 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

18323

18302

JANUARY 1900

JANUARY 1900

JANUARY 1900

JANUARY 1900

JANUARY 1900

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JANUARY 1900

MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13262

13274

1. DECEASED-NAME (Type or print) <b>CONVERSE OWEN SMITH</b>			2a. DATE OF DEATH Month <b>SEPT</b> Day <b>15</b> Year <b>1968</b>			2b. HOUR <b>12:00</b> P M	
3. SEX <b>M</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH <b>May 28, 1916</b>		6. AGE (In years last birthday) <b>52</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>AKRON, OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUBURBAN HOSP</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Spec. Asst. Secy of the Army</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>MONT</b>		13c. CITY OR TOWN <b>BETHESDA</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>37 W. IRVING ST</b>		14. FATHER'S NAME First Middle Last <b>HAROLD WATSON SMITH</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>CECIL WARD</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>W. 111 90-46</b>		17. INFORMANT <b>WIFE</b>		Address <b>37 W. IRVING ST</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ventricular fibrillation</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY SCLER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 sec</b> <b>3 h.</b> <b>3 yr.</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1966</b> to <b>15 SEPT, 1968</b> , that (I) (we) last saw the deceased alive on <b>29 July 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles W. Thompson MD</b>				22c. DATE SIGNED <b>15 Sept 68</b>		22d. PHYSICIAN'S NAME (Type) <b>CHARLES W. THOMPSON</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-18-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sea View Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Camden, Maine</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>SEP 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15  
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
13263 Item 13c, e, & 11, Film G405 10/2/68										
13275										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>DANIEL</b>			First Middle Last <b>I. SMITH</b>			2a. DATE OF DEATH Month <b>SEPT</b> Day <b>21</b> Year <b>1968</b>		2b. HOUR <b>9:20 AM</b>		
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>FEB 1906</b>		6. AGE (In years last birthday) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.				
10. CITY OR TOWN OF DEATH <b>GAITHERSBURG</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>REI. LABORER</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>NPNE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>MONTG.</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Box 295</b>	
14. FATHER'S NAME First Middle Last <b>ISIAH SMITH</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>F RANCES SMITH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS HENRIETTA SMITH</b>		Address <b>GAITHERSBURG, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129</b> <i>atherosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4200</b> <i>nme</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>6/1</b> , 19 <b>68</b> , to <b>9/21</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>9/18</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>James L. Hooper MD</b>						22c. DATE SIGNED <b>9/21/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>JAMES L. HOOPER M.D.</b>						22e. ADDRESS <b>13E DEER PARK RD GAITHERSBURG MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>9-24-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Emory Grove Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Gaithersburg Monty Md.</b>				
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>						25a. REC'D BY REGISTRAR <b>SEP 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



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DATE: 11-15-75 TIME: 10:30 AM

TO: [illegible] FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

FOR: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) <i>John Milton Smith</i>			2a. DATE OF DEATH Month <i>September</i> Day <i>2</i> Year <i>1968</i>			2b. HOUR <i>5:30 PM</i>					
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>4-2-1895</i>		6. AGE (In years last birthday) <i>73</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN. <i></i>			
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Maryland</i> Md.					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Potomac</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>10409 Ballhorn drive</i>	
14. FATHER'S NAME <i>Roger Bartel Smith</i>				15. MOTHER'S MAIDEN NAME <i>Marian Virginia Boswell</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>yes</i> (If yes give year or dates of service) <i>1916</i>				16b. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>Mr B B Smith - 1435 4th St SW Washington DC</i>					
CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchogenic carcinoma</i> <i>1621</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1621</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year <i>19</i> P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____						
22a. I certify that (I) (this hospital) attended the deceased from <i>FEB</i> , 19 <i>69</i> , to <i>2 SEPT</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>2 SEPT</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John M. Wyman</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>9/2/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>JOHN M. WYMAN</i>						22e. ADDRESS <i>7801 NORFOLK AVE. BETHESDA, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>9-5-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d. LOCATION (City or Town) (County) (State) <i>Wheaton Md</i>					
24. FUNERAL DIRECTOR <i>W.H. Chambers Co</i>						25a. REC'D BY REGISTRAR <i>Silver Spring Md</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
						DATE <i>SEP 10 1968</i>					



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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
13265 13277																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First MARTHA			Middle S.			Last SMITH			2a. DATE OF DEATH Month 9 Day 18 Year 1968			2b. HOUR 11:47 P.M.		
3. SEX female			4. RACE white			5. DATE OF BIRTH 2-21-1878			6. AGE (In years last birthday) 90 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Penn.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.								
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CAREY CHASE NURSING & REHAB. CENTER			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.			13b. COUNTY Washington			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 3731 Albermarle St. N.W.					
14. FATHER'S NAME First GERARD			Middle WYNCOOP			Last HAMILTON			15. MOTHER'S MAIDEN NAME First Elizabeth			Middle WYNCOOP			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 185-26-2641			17. INFORMANT Mrs. Marion Pender, Daughter, same as #13e			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>4129</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4221</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>2 yrs</u>					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 1968, to <u>Sept 18</u> , 1968, that (I) (we) last saw the deceased alive on <u>Sept 18</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Simon C. Weiner MD</u> DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> 22c. DATE SIGNED <u>Sept 18, 1968</u>																	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS <u>8201-16 St. Silver Spring Md.</u>														
23a. BURIAL, CREMATION, REMOVAL <u>Removal</u>			23b. DATE <u>9-19-1968</u>			23c. NAME OF CEMETERY OR CREMATORY <u>East Mahoning United Pres.</u>			23d. LOCATION (City or Town) (County) (State) <u>Indiana Co., Pa.</u>								
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sossn, Inc., 5130 Wisc. Ave.</u> <u>N.W., Wash., D.C., 20016</u>			ADDRESS			25a. REC'D BY REGISTRAR <u>SEP 23 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13266									
13278									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
MARY Cloressa SMITH						Month Day Year SEPTEMBER 25 1968		3:40 P M	
3. SEX			4. RACE			5. DATE OF BIRTH		6. AGE (In years last birthday)	
female			white			Sept. 27, 1867		100 YRS.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Virginia			U. S. A.					Montgomery Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Kensington			Carroll Hall San.			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
D.C.			Washington			DC		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
First Middle Last			First Middle Last			2301 Cathedral Ave. N.W.			
William W. Smith			Adalaide Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
no			none			Ida H. Sisson -2301 Cathedral Ave. N.W. Washington, D. C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (b) ESSENTIAL HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 SENILITY									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6-1, 1968, to 9-25, 1968, that (I) (we) last saw the deceased alive on SEPT. 25 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Henry M. Lowden						9/25/68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Henry M. Lowden						5206 1st St NW Chevy Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			9/27/68		Rock Creek Cemetery		Washington, D. C.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
The S.H. Hines Company						DATE SEP 30 1968		Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA R15 (4)  
30M REV. 1-60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13267					13279				
1. DECEASED-NAME (Type or print) First Middle Last Mary <del>Leona</del> Smith					2a. DATE OF DEATH Month Day Year 9 28 68			2b. HOUR 10:42M	
3. SEX Female		4. RACE white		5. DATE OF BIRTH 6-24-01		6. AGE (In years last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San + Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8405 Flower Ave.	
14. FATHER'S NAME First Middle Last Howard U. Skinner			15. MOTHER'S MAIDEN NAME First Middle Last Mattie Harper						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO. <del>38-85-2637</del>		17. INFORMANT Clarence Smith		Address Takoma Park 8405 Flower Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypernephroma with metastases 1890 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 180X (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease, Diabetes Mellitus									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo's
19a. DATE OF OPERATION 1 mo ago		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Nephrectomy for Ca		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9/25, 1968, to 9/28, 1968, that (I) (we) last saw the deceased alive on 9/28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Israel Spector MD						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/29/68	
22d. PHYSICIAN'S NAME (Type) ISRAEL SPECTOR MD						22e. ADDRESS 911 Silver Spring Ave, Silver Spring Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-2-1968		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City or Town) (County) (State) Rockville Montg. Md.			
24. FUNERAL DIRECTOR Clark E. Wisor Warner E. Humphrey, Inc. 8434 Georgia Ave.						25a. REC'D BY REGISTRAR DATE OCT 2 1968		25b. REGISTRAR'S SIGNATURE f Charles Judge	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a. Film 404 MARYLAND STATE DEPARTMENT OF HEALTH  
9-16-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13263

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13280

1. DECEASED-NAME (Type or Print) <b>TYFERRIL</b>			First Middle Last			20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>9-5 1968</b>			2b. HOUR <b>8:25 AM</b>		
3. SEX <b>Male</b>			4. RACE <b>Negro</b>			5. DATE OF BIRTH <b>8/20/68</b>			6. AGE (In years last birthday) <b>17</b> YRS. MONTHS <b>—</b> DAYS <b>—</b> HOURS <b>—</b> MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>Montgom</b>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>Rte I, Box 174</b>		
14. FATHER'S NAME <b>?</b> First Middle Last			15. MOTHER'S MAIDEN NAME <b>Frances Smith</b> First Middle Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		
17. INFORMANT <b>Mother</b>			ADDRESS <b>(same)</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Bronchopneumonia, bilateral</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) 485X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION <b>4/11X</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.			22b. DATE SIGNED <b>9/5/1968</b>			ADDRESS (City or Town or County)					
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>9-8-1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>John Wesley Cem</b>		
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>			ADDRESS <b>Rockville Md.</b>			25a. REC'D BY REGISTRAR <b>SEP 9 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



13380

REC'D EXHIBIT - CHARGE OF DEATH

13380

21112

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1132-1

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X

X

X

1132-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>William F. Smith</i>						2a. DATE OF DEATH <i>Sept 11 1968</i>			2b. HOUR <i>M</i>		
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>10/19/78</i>		6. AGE (In years lost birth day) <i>89</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery Md.</i>					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Teacher Training Inst. govt.</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Totomae</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>8520 Persimmon Tree Rd.</i>			
14. FATHER'S NAME First Middle Last <i>William Thompson Smith</i>				15. MOTHER'S MAIDEN NAME First Middle <i>Helen L. Ketcham</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <i>no</i>		(If yes give war or dates of service) <i>no</i>		16b. SOCIAL SECURITY NO. <i>220-44-0597</i>		17. INFORMANT <i>Mrs. Odessa S. Smith, Bethesda, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>sev yrs</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <i>4201</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>August 67</i> to <i>Sept 11, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept 11, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Michel M. Healy MD</i>						22c. DATE SIGNED <i>9/11/68</i>		22d. PHYSICIAN'S NAME (Type) <i>Michel M. HEALY MD</i>			
22e. ADDRESS <i>5411 Cedar La, Bethesda, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>9/14/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Bladensburg, Pr. Geo. Md.</i>					
24. FUNERAL DIRECTOR <i>Robert G. Humphrey</i>		ADDRESS <i>753 Wisconsin Ave. Bethesda, Md.</i>		25a. REC'D BY REGISTRAR <i>SEP 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

13581

RECORDS OF DEATH

13581

1

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 11-11-88 BY 1043

SEP 18 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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13270

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13282

1. DECEASED-NAME (Type or print) <b>GRACE F. SMYTHE</b>			2a. DATE OF DEATH Month <b>SEPT.</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>12:15</b> M				
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>8/11/1879</b>		6. AGE (In years lost birthday) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.				
10. CITY OR TOWN OF DEATH <b>GERMANTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>THE MARYLANDER HOME OF RES. IN Ret. Government Emp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Conn.</b> CITY <b>Southport</b>			13b. CITY OR TOWN <b>Southport</b>			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER <b>9444 Pequot Road</b>	
14. FATHER'S NAME First <b>Charles</b> Middle <b>H.</b> Last <b>Fiske</b>			15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>M</b> Last <b>Rockwell</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>047-42-0003</b>			17. INFORMANT <b>Records</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>401x Hepatic static pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Advanced generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 years</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>444x Hypertension</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 8, 1968</b> , to <b>Sept 9, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept 8, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John G. Fawcett</b> DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>9/9/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>John G. Fawcett, M.D.</b>						22e. ADDRESS <b>Dawsonville, Maryland 20720</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>9/11/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Indianapolis, Ind.</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b> ADDRESS <b>1351 Rockville Road, Rockville, Maryland</b>						25a. REC'D BY REGISTRAR <b>SEP 11 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 **13283**  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Arthur (NMN) Sparks</b>			2a. DATE OF DEATH Month <b>September</b> Day <b>8</b> Year <b>1968</b>		2b. HOUR <b>AM</b> <b>9:05 M</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>5 December 1917</b>		6. AGE (In years lost birthday) <b>50</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Oklahoma</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Montgomery</b>			Md.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housing Inspector</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>City Gov't</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>	
13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>11605 Highview Avenue</b>			
14. FATHER'S NAME First <b>Gabriel</b> Middle <b></b> Last <b>Sparks</b>		15. MOTHER'S MAIDEN NAME First <b>Kate</b> Middle <b></b> Last <b>Smith</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>Yes</b> (If yes, give war or dates of service) <b>1940-1960</b>		16b. SOCIAL SECURITY NO. <b>442-12-9541</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intrathoracic Hemorrhage</b> <b>2051</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pleural Biopsy</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Chronic Myelocytic Leukemia</b> <b>3 1/2 Years</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2041</b>					
19a. DATE OF OPERATION <b>9/6/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Left Pleural Effusion</b>		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>September 4, 1968</b> to <b>September 8, 1968</b> , that <b>he</b> (we) last saw the deceased alive on <b>September 8, 1968</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>he</b> (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Sherrard L. Hayes M.D.</b>				22c. DATE SIGNED <b>9/9/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Sherrard L. Hayes, M. D.</b>				22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/10/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
23d. LOCATION (City or Town) <b>Arlington, Virginia</b>		(County) (State)			
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home 1331 Rockville Road, Rockville, Maryland</b>				25a. REC'D BY REGISTRAR <b>Pike</b> DATE <b>SEP 11 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove callow papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13283

## CERTIFICATE OF DEATH

Date of Death		Place of Death		Cause of Death	
September 8, 1968		Spokane		(RMS)	
Age		Sex		Race	
79		Male		White	
Marital Status		Place of Birth		Country of Birth	
Married		USA		USA	
Residence		The Clinical Center, 1411 Broadway Avenue, Spokane, WA 99201		The Clinical Center, 1411 Broadway Avenue, Spokane, WA 99201	
Physician		Hospital		Physician	
Dr. J. H. H. H.		The Clinical Center		Dr. J. H. H. H.	
Date of Admission		Date of Discharge		Date of Death	
10-1-68		10-1-68		10-1-68	
Admission Diagnosis		Discharge Diagnosis		Cause of Death	
Ischemic Heart Disease		Ischemic Heart Disease		Ischemic Heart Disease	
Myocardial Infarction		Myocardial Infarction		Myocardial Infarction	
Coronary Atherosclerosis		Coronary Atherosclerosis		Coronary Atherosclerosis	
Hypertension		Hypertension		Hypertension	
Diabetes Mellitus		Diabetes Mellitus		Diabetes Mellitus	
Chronic Kidney Disease		Chronic Kidney Disease		Chronic Kidney Disease	
Liver Disease		Liver Disease		Liver Disease	
Lung Disease		Lung Disease		Lung Disease	
Stomach Disease		Stomach Disease		Stomach Disease	
Intestine Disease		Intestine Disease		Intestine Disease	
Urinary System Disease		Urinary System Disease		Urinary System Disease	
Reproductive System Disease		Reproductive System Disease		Reproductive System Disease	
Other Disease		Other Disease		Other Disease	
Cause of Death		Cause of Death		Cause of Death	
Ischemic Heart Disease		Ischemic Heart Disease		Ischemic Heart Disease	
Myocardial Infarction		Myocardial Infarction		Myocardial Infarction	
Coronary Atherosclerosis		Coronary Atherosclerosis		Coronary Atherosclerosis	
Hypertension		Hypertension		Hypertension	
Diabetes Mellitus		Diabetes Mellitus		Diabetes Mellitus	
Chronic Kidney Disease		Chronic Kidney Disease		Chronic Kidney Disease	
Liver Disease		Liver Disease		Liver Disease	
Lung Disease		Lung Disease		Lung Disease	
Stomach Disease		Stomach Disease		Stomach Disease	
Intestine Disease		Intestine Disease		Intestine Disease	
Urinary System Disease		Urinary System Disease		Urinary System Disease	
Reproductive System Disease		Reproductive System Disease		Reproductive System Disease	
Other Disease		Other Disease		Other Disease	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A		
Frank Sparks, Jr					Sept. 12 1968			1220		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		Negro		Nov. 27, 1928		39 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
Virginia		USA								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Naval Hospital			U. S. Navy				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Pr. George		Seat Pleasant				615 72nd Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Frank Sparks, Sr.			Bernethia Taylor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
Yes 1948-68					Pleasant, Md. Address Mrs. Barbara Sparks, 615 72nd St., Seat					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 5900 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic cyclonephritis, anemia, hypertension 4 years.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 6000									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours 6 hours	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Aug. 2, 1968, to Sept. 12, 1968, that (I) (we) last saw the deceased alive on Sept. 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John A. Routenberg						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Sept. 12, 1968		
22d. PHYSICIAN'S NAME (Type) John A. Routenberg, M. D.						22e. ADDRESS Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		9/17/68		Arlington National Cemetery			Arlington, Virginia			
24. FUNERAL DIRECTOR Stuart Funeral Home 4001 Benning Road, N. E. Washington, D.C.						25a. RECEIVED BY REGISTRAR DATE SEP 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

20

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13272

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13285

1. DECEASED-NAME (Type or Print)		First HENRY	Middle M	Last STEPHEN	2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 9 27 1968		2b. HOUR 7:25A
3. SEX Male	4. RACE White	5. DATE OF BIRTH 4/11/ 25		6. AGE (In years last birthday) 45 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 9 Day 27 Year 19 68 7:25A
7a. BIRTHPLACE (State or foreign country) Boston, Mass		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Foreign Service		12b. KIND OF BUSINESS OR INDUSTRY USIA	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase Md		13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Stephen		Middle Hajenian		Last ?		15. MOTHER'S MAIDEN NAME First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 1942-45		17. INFORMANT wife Karin		ADDRESS 2937 Terrace Dr. CC Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency - Acute -</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arteriosclerosis -</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4201</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		JOHN G. BALL, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Sept. 27, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/30/68		23c. NAME OF CEMETERY OR CREMATORY Gettysburg Nat. Cem.		23d. LOCATION (City or Town) (County) (State) Gettysburg, Adams Co. Pa.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland.		7557 Wisconsin Ave. ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 2 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	



13885

RECEIVED

13885

RECEIVED



OCT 5 1960

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 405 10-1-1 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13273		13286			
1. DECEASED-NAME (Type or Print) First Middle Last <b>Martha L Stoehr</b>						2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 9 14 1968 3 3 PM				2b. HOUR					
3. SEX <b>Fe.</b>		4. RACE <b>W.</b>		5. DATE OF BIRTH <b>Feb. 22, 1912</b>		6. AGE (In years last birthday) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 14 Sept 9 1968 3 12 PM		2d. HOUR	
7a. BIRTHPLACE (State or foreign country) <b>No. Carolina</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b>				Md.		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>(RN) Home wife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Montgomery</b>				13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>415 Silver Spring Ave</b>			
14. FATHER'S NAME First Middle Last <b>Edwin Copeland, Sr.</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Elinor Wheeler</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. <b>YES</b>		17. INFORMANT <b>Henry W. Stoehr</b>				ADDRESS <b>Sil. Spr., Md. 415 Silver Spring Avenue</b>					
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERITONITIS</b> Coronary insufficiency, acute <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Coronary arteriosclerosis - severe</b> Years DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>															
19a. DATE OF OPERATION <b>9/14/1968</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Partial Intestinal Obstruction</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>John G. Ball</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <b>John G. Ball</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
						ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				23b. DATE <b>9-16-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Crematory</b>				23d. LOCATION (City or Town) (County) (State) <b>Prince Georges, Md.</b>					
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc. 8434 Ga. Ave., Sil. Sp. Md.</b>						25a. REC'D BY REGISTRAR <b>SEP 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR Min		
John Richard Sullivan						September 17, 1968		1:15 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		white		April 20, 1873		95 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		America U.S.A.				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington Sanitarium Nat'l Cap. park & planning							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery		Silver Spring		YES		2000 Atwood Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
John Sullivan			Caroline Burriss							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no			214-03-8850		Margaret U. Sullivan Patient's chart		2000 Atwood Rd. S.S. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 month</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>493x Generalized arteriosclerosis &amp; Prostatitis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>12/16/68</u> , 19 <u>68</u> , to <u>9/16/68</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>9/16/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Patrick C. Jameson</u> M.D.						22c. DATE SIGNED <u>9/16/68</u>				
22d. PHYSICIAN'S NAME (Type) <u>Patrick C. Jameson, MD.</u>						22e. ADDRESS <u>11718 Georgia Scher Spring Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		9-20-1968		Friends Cemetery		Sandy Springs Montg. Md.				
24. FUNERAL DIRECTOR <u>C. Glen Carter &amp; Son</u> <u>Warner E. Pumphrey, Inc.</u>						25a. REC'D BY REGISTRAR DATE <u>SEP 20 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13275 Item 6 Film 405 10/3/68 13288									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Mary Clara SUTTORA						Sept. Month 29 Day Year 68			724 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasen		Oct. 11, 1887		91 80 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Austria		U.S. A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		N/A	
Bethesda		Naval Hospital		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Bethesda				5618 Alta Vista Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Unknown			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO.-A		17. INFORMANT		Address			
No		550-52-5561		Atton W. Suttora		Md/ 5618 Alta Vista Rd. Bethesda			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 398X CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF HEART DISEASE (b) RHEUMATIC HEART DISEASE AND ARTERIOSCLEROTIC DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								416X	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
22a. I certify that (this hospital) attended the deceased from 705 P 29 Sept 19 68, to 724 P 29 Sept 19 68, that (we) last saw the deceased alive on 29 Sept. 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Charles S. Crummy M.D.						Sept. 30, 1968			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
CHARLES S. CRUMMY, M.D.						Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		10/3/68		Holy Sepulcher Cemetery		Orange,		California	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey				DATE OCT 2 1968		f Charles Judge			
Funeral Home, 7557 Wisconsin Ave. Bethesda, Md.									

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

828 • J. Neurosci., July 26, 2006 • 26(30):824–830

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13276										MARYLAND STATE DEPARTMENT OF HEALTH										13289																													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH																																							
1. DECEASED-NAME (Type or print) First Middle Last SOPHIE SWIRNOFSKY										2a. DATE OF DEATH Month Day Year Sept. 16th 1968										2b. HOUR P 10:25M																													
3. SEX Female										4. RACE White										5. DATE OF BIRTH May 22, 1892										6. AGE (In years lost birthday) YRS. 76										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Russia										7b. CITIZEN OF WHAT COUNTRY? Russia										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Montgomery Md.																			
10. CITY OR TOWN OF DEATH Bethesda										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife										12b. KIND OF BUSINESS OR INDUSTRY -----																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE N.Y.										13b. COUNTY -----										13c. CITY OR TOWN Bronx										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 3311 Giles Place									
14. FATHER'S NAME First Middle Last Max Margolies										15. MOTHER'S MAIDEN NAME First Middle Last Rachel -----																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No -----										16b. SOCIAL SECURITY NO. 059-12-9724D										17. INFORMANT Address Mrs. Rose Levine 5213 Rayland Dr., Beth, Md.																													
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachupia 1991 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis, primary site unknown DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-6 mos.																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1992																																																	
19a. DATE OF OPERATION 1992										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 5-23-68, to 9-13-68, that (I) (we) last saw the deceased alive on 9-13-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE George Gray, M.D.										22c. ATTENDING PHYSICIAN MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22d. DATE SIGNED 9-11-68																													
22e. PHYSICIAN'S NAME (Type) George Gray, M.D.										22f. ADDRESS 4740 Chevy Chase Dr., Bethesda, Md.																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 9-19-68										23c. NAME OF CEMETERY OR CREMATORY Wellwood Cem.										23d. LOCATION (City or Town) (County) (State) Farmingdale, L.I., N.Y.																			
24. FUNERAL DIRECTOR Goldberg Funeral Home 4217 9th St NW										25a. REC'D BY REGISTRAR SEP 19 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 15 (4)  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13277		13290							
1. DECEASED-NAME (Type or print) First Middle Last EMMA LOUISE TAYLOR					2a. DATE OF DEATH Month Day Year 9 8 68			2b. HOUR 8:50 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 2-14-80		6. AGE (In years lost birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Ashton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER New Hampshire Avenue	
14. FATHER'S NAME First Middle Last George W. Reynolds				15. MOTHER'S MAIDEN NAME First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 215-54-8233		17. INFORMANT Address John E. Taylor, Son, 1113 Agnew Dr, Rockville Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4200 (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis, Urinary tract infection</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day 1-2 days years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1968</u> , to <u>Sept 8, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John R. Spencer, MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22c. DATE SIGNED 9-8-68	
22d. PHYSICIAN'S NAME (Type) John R. Spencer, M.D.		22e. ADDRESS BURTONSVILLE, MD.							
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE 9/11/68		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore City, Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1331 Rockville Road, Rockville, Maryland				25a. REC'D BY REGISTRAR Pik SEP 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



13330

UNITED STATES OF AMERICA

13330

TO: THE DIRECTOR, FBI (100-388610) FROM: SAC, NEW YORK (100-100000) (P)

SUBJECT: JAMES EARL RAY; AKA; FUGITIVE; RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

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RE: NEW YORK TELETYPE TO BUREAU, 10/10/68.

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13278

13291

1. DECEASED NAME (Type or Print) <b>WALTER First Middle Last</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>9/14 1968 10 30 PM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>4/3/17</b>	6. AGE (in years last birthday) <b>51 YRS.</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
9. COUNTY OF DEATH <b>Montgomery</b>		10. CITY OR TOWN OF DEATH <b>Takoma Park</b>	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington San &amp; Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Clerk</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>	
13b. COUNTY <b>Prince George's Hyattsville</b>		13c. CITY OR TOWN <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>1009 Chillum Rd.</b>	
14. FATHER'S NAME First <b>Arunah</b> Middle <b>Thomas</b> Last <b>Hallock</b>		15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Hallock</b> Last <b>hallock</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WWII</b>	
17. INFORMANT <b>Hospital Record</b>		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to aspiration of Gastric Contents</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Insufficiency Acute.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardio Vascular Disease -</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b> <b>Sudden.</b> <b>years.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>19</b>	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John G. Ball</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-19-68</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		ADDRESS <b>Washington, D.C.</b>	
25a. REC'D BY REGISTRAR <b>SEP 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 404 Maryland State Department of Health  
9-25-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13279

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13292

1. DECEASED-NAME (Type or Print) First Middle Last <b>Addie Hensley Thompson</b>			2a. DATE KNOWN OF DEATH Month Day Year <b>9-9-1968</b>			2b. HOUR 10:45A			
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>3-31-1888</b>	6. AGE (In years last birthday) <b>80</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <b>9-9-1968</b>		2d. HOUR M
7a. BIRTHPLACE (State or foreign country) <b>Tenn</b>		7b. CITIZEN OF WHAT COUNTRY? <b>America</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Takoma Pk</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. San &amp; Hosp</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>none</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>216 Hillmoor Dr</b>	
14. FATHER'S NAME First Middle Last <b>John W. Hensley</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Blanche Dromgoole</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>225-66-0492</b>		17. INFORMANT <b>Katherine Crow, Niece</b>			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary insufficiency, acute</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Trauma from fall</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>24 hrs.</b> <b>48 hrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>904.7 Fracture of rt. hip</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>9:30 PM 9/7/ 19 68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Fell in Nursing Home causing fracture of rt. hip</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Colonial Villa Nursing Home</b>		21f. LOCATION Street or R.F.D. No. <b>Silver Spring</b>		City or Town <b>Montgomery</b>		State <b>Md.</b>	
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></b>									
ACTUAL SIGNATURE <b>Belden R. Keap</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type or Print) <b>BELOEN R. KEAP M.D.</b>		ADDRESS <b>5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>		23a. REC'D BY REGISTRAR DATE <b>SEP 13 1968</b>		23b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-11-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Bladensburg, Prince Georges, Md.</b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.,</b>		ADDRESS <b>5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13280

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13293

1. DECEASED-NAME (Type or print)		First <b>Harold</b>	Middle <b>Cecil</b>	Last <b>TRAIN</b>	2a. DATE OF DEATH Month <b>9</b> Day <b>7</b> Year <b>1968</b>		2b. HOUR <b>PM</b> <b>10:28</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>15 OCT 1887</b>		6. AGE (In years last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Kansas City Mo.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Bethesda, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Military</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>WDC</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3140 Wisconsin Ave. N.W.</b>
14. FATHER'S NAME First <b>Harold</b> Middle <b>Depue</b> Last <b>Train</b>		15. MOTHER'S MAIDEN NAME First <b>Dora</b> Middle <b>Langdon</b> Last <b>Train</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>217 34 3095A</b>		17. INFORMANT Address <b>May P. Train 3140 Wisconsin Ave. N.W. WDC</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> <b>1541</b> DUE TO, OR AS A CONSEQUENCE OF <b>Rectum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adenocarcinoma status Post Operative</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>154x</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>8 July</b> , 19 <b>68</b> , to <b>7 Sept</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7 Sept</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.								
22b. SIGNATURE <b>F. Keenan</b>		22c. DATE SIGNED <b>9 September 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>F. KEENAN LT MC USN</b>				
22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-10-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Naval Academy Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Annapolis, Maryland</b>		
24. FUNERAL DIRECTOR <b>Taylor Funeral Home</b>		ADDRESS <b>, Annapolis, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

24561

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13294

1. DECEASED NAME (Type or Print) <b>James Andrew Trutter Jr.</b>			First Middle Last			2a. DATE KNOWN OF DEATH Month Day Year <b>9-4 1968</b>			2b. HOUR M				
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>11-21-43</b>		6. AGE (In years last birthday) <b>24 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <b>Florida</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			2c. DATE PRONOUNCED DEAD Month Day Year <b>9-4 1968</b>			2d. HOUR M	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash San &amp; Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Unemployed</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Sp.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1544 Live Oak Dr.</b>			
14. FATHER'S NAME First Middle Last <b>James A. Trutter</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Florence Daigle</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>264-68-8352</b>		17. INFORMANT <b>Colonel James A. Trutter</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple extreme injuries</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>incurred in auto accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>814.7</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>812.4</b>													
19a. DATE OF OPERATION <b>812.4</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>6:00 PM 9/4 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Deceased walking along median strip of Rte 495 when struck by car</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Street</b>				21f. LOCATION Street or R.F.D. No. City or Town County State <b>Silver Spring Montg Md.</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>BELDEN R. REAP</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>9/4/1968</b>					
EXAMINER'S NAME (Type) <b>BELDEN R. REAP</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>9-6-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>		25a. REC'D BY REGISTRAR <b>SEP 9 1968</b>			
24. FUNERAL DIRECTOR <b>Warner E. Humphrey, Inc.</b>				ADDRESS <b>8434 Georgia Ave. S.S. Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

10881

10881



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13282				MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				13295			
1. DECEASED-NAME (Type or print) First Middle Last Edith Louise Tschiffely				2a. DATE OF DEATH Month Day Year September 1, 1968				2b. HOUR 4:15 P.M.			
3. SEX Female		4. RACE white		5. DATE OF BIRTH August 27, 1880		6. AGE (In years lost birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY Prince Georges		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4900 Wicomico Avenue			
14. FATHER'S NAME First Middle Last Jacob (unknown) Parker		15. MOTHER'S MAIDEN NAME First Middle Last Sarah (unknown) Sanderson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO. 578-62-3193		17. INFORMANT Hospital record Address 1600 Carroll Ave. Washington Sanitarium & Hospital Takoma Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>malignant tumor of pancreas</u> 157.9 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 157.8 <u>old age</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> , 19 <u>68</u> , to <u>9/1</u> , 19 <u>68</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>9/1</u> , 19 <u>68</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE <u>Philip Bloemsa</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9-1-68					
22d. PHYSICIAN'S NAME (Type) Philip Bloemsa		22e. ADDRESS 7701 Conn. Av		Cherry Chase Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept 4, 1968		23c. NAME OF CEMETERY OR <del>INTERMENT</del> St Johns Episcopal		23d. LOCATION (City or Town) (County) (State) Beltsville Pro Geo Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE SEP 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



13595

13595

UNITED STATES OF AMERICA

Sept 1, 1908 - 25 years ago

Sept 1, 1908

Sept 1, 1908

Sept 1, 1908

Sept 1, 1908

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

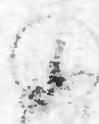
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 1 Film 409 2/18/69 MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13283 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13296									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR	
H. James			Malcolm Turton			9/21/68		11:45 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR
M	Cauc.	Jan-16-1902		66 YRS.			Sept-22-68		5:30 AM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			7406 Fairfax Rd.						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland			Montgomery		Bethesda	7406 Fairfax Road.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last William H Turton			First Middle Last Margaret Niland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS		
NO			217-44-0145		Dorothy C Turton		7406 Fairfax Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute -</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cor Pulmonale due to severe emphysema and Mediastinum shift to Rt.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4129									Sudden.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4301									years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			John G. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Sept 22, 1968	
EXAMINER'S NAME (Type)			John G Ball			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		9-26-68		Glenwood Cemetery		Washington, D. C.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert A Pumhrey		7557 Wisconsin Ave Bethesda, Md.		SEP 27 1968		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*1 - Crown satisfied Dr. John H. ...*

13284												13297											
1. DECEASED-NAME (Type or print) First Middle Last GEORGE FRANKLIN ULLMAN												2a. DATE OF DEATH Month Day Year 9 11 68						2b. HOUR 156 P M					
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH FEB 28 1883			6. AGE (In years lost birthday) 85 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) New York				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH MONTGOMERY Md.											
10. CITY OR TOWN OF DEATH Pasadena				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CASA HAVEN				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Manager				12b. KIND OF BUSINESS OR INDUSTRY Office Manager											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Montgomery				13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 14326 Yosemite Court											
14. FATHER'S NAME First Middle Last Unknown						15. MOTHER'S MAIDEN NAME First Middle Last Unknown																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no				16b. SOCIAL SECURITY NO. 074-05-7005				17. INFORMANT Mc Lee Ullmann-Rockville, Md.				Address 14326 Yosemite Court - 929-3199											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic atherosclerotic heart disease</u> stating the underlying cause last. (c) <u>yes</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4200																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from 8/21, 19 68, to 9/11, 19 68, that (I) (we) last saw the deceased alive on 8/21, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Chas H. Wolohan, M.D.										DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 9/11/68					
22d. PHYSICIAN'S NAME (Type) Chas H. Wolohan										22e. ADDRESS 1401 Blair Rd NW Wash DC													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Sept. 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Morningside Cemetery				23d. LOCATION (City or Town) (County) (State) Syracuse, New York													
24. FUNERAL DIRECTOR C. Glen Carter 8434 Georgia Ave. Warner C. Humphrey, Inc. Silver Spring, Md.														25a. REC'D BY REGISTRAR DATE SEP 16 1968				25b. REGISTRAR'S SIGNATURE Charles Judge					

1933

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

13285

CERTIFICATE OF DEATH

13298

1. DECEASED-NAME (Type or print) <b>GORDON</b>			First <b>JOSEPH</b>			Middle <b>UMSTEAD</b>			Lost			2a. DATE OF DEATH Month <b>9</b> Day <b>19</b> Year <b>68</b>			2b. HOUR <b>7:20A.</b>					
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>2-1-13</b>			6. AGE (In years last birthday) <b>55</b> YRS.			IF UNDER 1 YEAR MONTHS <b>55</b> DAYS <b>19</b> HOURS <b>68</b> MIN.			IF UNDER 24 HRS. HOURS <b>7:20A.</b> MIN.					
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.											
10. CITY OR TOWN OF DEATH <b>OLNEY</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CHICKEN FARMER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>POULTRY</b>											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>			13c. CITY OR TOWN <b>OLNEY</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>17328 GEORGIA AVENUE</b>								
14. FATHER'S NAME First <b>MAURICE</b> Middle <b>A.</b> Lost <b>UMSTEAD</b>			15. MOTHER'S MAIDEN NAME First <b>BERTHA</b> Middle <b>KING</b> Lost																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>216 18 7616</b>			17. INFORMANT Address <b>MEDICAL RECORDS</b>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of kidney - secondary metastasis</b> <b>1890</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 Months</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>180X</b>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>55</b> , to <b>Sept 19</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Sept 19</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <b>we</b> ) (did) ( <b>did not</b> ) view the body after death.																				
22b. SIGNATURE <b>A. D. Bonifant</b>															DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>9/19/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M.D.</b>			22e. ADDRESS <b>SANDY SPRING MEDICAL CENTER, SANDY SPRING</b>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Sept. 21 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>			23d. LOCATION (City or Town) (County) (State) <b>Rockville Mont Md.</b>											
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>			ADDRESS <b>Laytonsville Md.</b>			25a. REC'D BY REGISTRAR DATE <b>SEP 23 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>											

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STO 18 1010

*Conium maculatum* L.

2001 12 13 1950 St Marys

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"Traveler"

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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Isabel Fletcher Utegaard</b>		First Middle Last		2a. DATE OF DEATH Month <b>Sept.</b> Day <b>22</b> Year <b>1968</b>		2b. HOUR <b>4:15 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>1897</b>		6. AGE (In years last birthday) <b>71</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Utah</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Grosvenor Lane Nursing and Convalescent Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>6200 Carnegie Drive</b>		14. FATHER'S NAME First Middle Last <b>John Fletcher</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Katherine Daly Smith</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>392-10-8697D</b>		17. INFORMANT <b>Thomas Utegaard Same as #13e Son</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of the brain</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH? <b>sev. wks</b> <b>sev. months</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>163X Chronic Brain Syndrome</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/16</b> , 19 <b>68</b> , to <b>9/23</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>9/20</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9/23/68</b>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>9-23-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home 300-4th St, N.E. Wash. D.C.</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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SEP 2 1968

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13287

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13300

**Item #5,6, Film G405 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or Print)		First <b>NICHOLAS</b>		Middle <b>M.</b>	Last <b>VARRELLA</b>		2a. DATE KNOWN OF DEATH Month Day Year <b>Sept. 2, 1968</b>		2b. HOUR P M <b>5:20 P M</b>		
3. SEX <b>Male</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH <b>4-18-1918</b>		6. AGE (In years last birthday) <b>50</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <b>9-2-68</b>		
7a. BIRTHPLACE (State or foreign country) <b>Wash, D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Empl.</b>			
10. CITY OR TOWN OF DEATH <b>Glen Echo</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>22 Wellesley Circle</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Recreation Center</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md. Montgomery</b>				13b. CITY OR TOWN <b>Glen Echo</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>22 Wellesley Circle</b>			
14. FATHER'S NAME First Middle Last <b>Nicholas Varrella</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Emilia Tranchitella</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>578-20-7549</b>		17. INFORMANT <b>Wife</b> <b>Lottie Varrella</b>		13e. STREET AND NUMBER <b>Same as Item 13.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the Pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>with generalized</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <b>157x</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Belden R. Reap</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>SEPT. 2, 1968</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP</b>				ADDRESS <b>Wheaton, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-6-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>					
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



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MEDICAL EXAMINING CENTRAL OFFICE

HEALTHIER

NAME: [illegible] DATE: [illegible]

AGE: [illegible] SEX: [illegible]

HEIGHT: [illegible] WEIGHT: [illegible]

TEMPERATURE: [illegible] PULSE: [illegible]

BLOOD PRESSURE: [illegible]

RESPIRATORY RATE: [illegible]

EXAMINER: [illegible]

DATE: [illegible]

TIME: [illegible]

LOCATION: [illegible]

REMARKS: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

TIME: [illegible]

LOCATION: [illegible]

REMARKS: [illegible]

SIGNATURE: [illegible]

DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13288

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

13301

1. DECEASED-NAME (Type or print) <i>Saatore E. Verzani</i>		First Middle Last		2a. DATE OF DEATH Month Day Year <i>Sept. 16 1968</i>		2b. HOUR <i>3:30</i> M	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>4/3/26</i>		6. AGE (In years lost birthday) <i>42</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Contractor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S.A. Gov't</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Wheaton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>12103 Valleywood</i>		14. FATHER'S NAME First Middle Last <i>Vincenzo Verzani</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Maria Leto</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>yes</i> (If yes give war or dates of service) <i>1945-1946</i>	
16b. SOCIAL SECURITY NO. <i>577-36-0618</i>		17. INFORMANT <i>Mrs Virginia Verzani</i>		Address <i>above wife</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarct</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Thrombosis circumflex coronary A.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis of coronary vessels</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>7/13</i> , 19 <i>68</i> , to <i>9/16</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Sept 16</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>DeWitt E. DeLauxer</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <i>DeWitt E. DeLauxer</i>				22e. ADDRESS <i>3848 Porter St NW Wash DC</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-20-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville Montg. Maryland</i>	
24. FUNERAL DIRECTOR <i>C. Glen Carter</i>				ADDRESS <i>Warner E. Dunham, 920 8434 Ga. Ave. S.E. Md.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 20 1968</i>	
				25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

13289		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		13302	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) <b>LEO</b>		First <b>J</b> Middle <b>WALDRON</b> Last		2a. DATE OF DEATH Month <b>9</b> Day <b>25</b> Year <b>68</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>6/25/03</b>	
7a. BIRTHPLACE (State or foreign country) <b>Mich.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (In years last birthday) <b>65</b> YRS.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. CITY OR TOWN <b>Montgomery Kensington</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>Edward Waldron</b>		15. MOTHER'S MAIDEN NAME <b>Emelia Foerch</b>		13d. STREET AND NUMBER <b>3711 Farragut Ave</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-44-9458</b>		17. INFORMANT <b>Carol B. Waldron - wife - same item #</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure &amp; renal shutdown</b> <b>4379</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerosis, generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>334X Stroke in past</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dr. Morris Perry</b>		DEGREE <b>MD.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>9-25-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Morris Perry</b>		22e. ADDRESS <b>11602 Georgia Ave. Silver Spring Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/28/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>					
24. FUNERAL DIRECTOR <b>Tyson Wheeler</b>		1331 Rockville Pike <b>Rockville, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 30 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 through 5 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div>13290</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>13303</div>										
1. DECEASED-NAME (Type or Print) <b>ETHEL</b>			First Middle Last <b>WALKER</b>			20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>9 20 1968</b>		2b. HOUR <b>8:30 PM</b>		
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>8/20/84</b>		6. AGE (In years last birthday) <b>84</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year <b>Sept 20 1968</b>		
70. BIRTHPLACE (State or foreign country) <b>IND.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b>				
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>HOLY CROSS HOSP.</b>			120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>MONT.</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>13204 BELLEVUE ST</b>	
14. FATHER'S NAME First Middle Last <b>John Dalton</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Ella Golden</b>							
160. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO. <b>301-6-1326</b>		17. INFORMANT <b>Silver Spring, Md. Mrs. D. Ellett-Daughter</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Cardio Vascular Disease -</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36h.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>9047 Fracture of Rt Hip.</b>										
19a. DATE OF OPERATION <b>Sept 18, 1968</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Repair of Fracture of Rt hip.</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
210. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>7 P.M. Sept 14 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) <b>Fall in nursing home fracture of Rt hip.</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Nursing home -</b>		21f. LOCATION Street or R.F.D. No. City or town County State <b>Greenbelt Convalescent Center Greenbelt - RG. Md.</b>						
220. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>John G. Ball</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>Sept 20, 1968</b>				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
			ADDRESS (Street, city, town, or county)							
230. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/24/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mitchell Christian Church</b>		23d. LOCATION (City or Town) (County) (State) <b>Mitchell, Indiana</b>				
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc. 8434 Ga. Ave. S. S. Md.</b>					250. REC'D BY REGISTRAR <b>SEP 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

2022

GR 31

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

13291										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										13304																																							
1 DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																													
Baby										Boy										WARD										Sept. 25 Day Year 68										0835 A M																			
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
Male										Negro										Sept. 24, 1968										YRS.										15 53																			
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
Maryland										USA																				Montgomery																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
Bethesda										Naval Hospital										N/A										N/A																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
D. C.										Washington										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										3330 4th St., S. E.																													
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										First Middle Last										First Middle Last																													
Roosevelt										D. WARD										Cora J. Donnell																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
N/A										N/A										Washington										D. C.																													
										Roosevelt D. Ward, 3330 4th St., S. E.																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
7769										DUE TO, OR AS A CONSEQUENCE OF										Atelectasis, compatible with hyaline membrane disease																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										DUE TO, OR AS A CONSEQUENCE OF																																							
										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										7620																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										Yes																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
HOUR A.M. Month Day Year										P.M. 19																																																	
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION										Street or R.F.D. No. City or Town County State																													
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>																																																											
22a. I certify that (I) (this hospital) attended the deceased from Sept. 24, 1968, to Sept. 25, 1968, that (I) (we) last saw the deceased alive on Sept. 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED										22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																													
B. Jay Bortz										Sept. 25, 1968										B. Jay BORTZ, M.D.										Naval Hospital, Bethesda, Md.																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Removal										9/25/1968										Naval Medical School										NMMC, Bethesda, Md.																													
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
																				DATE										SEP 27 1968																													

SEP 27 1968

10081

PLATE 10-10-10-10

10081



10081 10081 10081

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13292

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13305

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
NATHAN			NMI Wartel			Month 9 Day 2 Year 68			7:30 AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
Male		White		7/20/08		60 YRS.		MONTHS DAYS		HOURS MIN.		Month 9 Day 2 Year 68		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
New York City			USA						Montgomery			Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring			Holy Cross Hospital			engineer/draftsman			Government					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Maryland			Montgomery			SSMd.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			10905 Amherst Ave. SSMd.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
Louis NMI Wartel			Rose ?			none			067-01-9314			wife Berneta 10905 Amherst Ave. SSMd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF														
4129 Acute Coronary Insufficiency														
Coronary Artery Heart Disease														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)														
4201														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
22b. DATE SIGNED			22c. SIGNATURE			22d. SIGNATURE			22e. SIGNATURE			22f. SIGNATURE		
9/2/1968			Belden R. Reap M.D.			Belden R. Reap M.D.			Belden R. Reap M.D.			Belden R. Reap M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF EXEMPTED SCHOOL			23d. LOCATION (City or town) (County) (State)			23e. REGISTRAR'S SIGNATURE		
			9-3-68			GEORGE WASHINGTON SCHOOL OF MEDICINE (ANATOMICAL)			WASHINGTON, D.C.			SEP 6 1968		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
JOSEPH GA			WHLERS SONS, INC. WASH., D.C.			SEP 6 1968			Charles Judge					



13305

RECEIVED

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WASHINGTON, D.C.

SEP 8 1966

13293

CERTIFICATE OF DEATH

13306

1. DECEASED NAME (Type or print) <u>Margaret</u>			First <u>Waskiewicz</u>			Middle <u>Waskiewicz</u>			Last <u>Waskiewicz</u>			2a. DATE OF DEATH Month <u>Sept</u> Day <u>28</u> Year <u>1968</u>			2b. HOUR <u>50</u> <u>PM</u>					
3. SEX <u>Female</u>			4. RACE <u>Caucasian</u>			5. DATE OF BIRTH <u>9-15-16</u>			6. AGE (In years last birthday) <u>52</u> YRS.			IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u> HOURS <u>  </u> MIN. <u>  </u>			IF UNDER 24 HRS. HOURS <u>  </u> MIN. <u>  </u>					
7a. BIRTHPLACE (State or foreign country) <u>Iowa</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Montgomery</u> Md.											
10. CITY OR TOWN OF DEATH <u>Springfield</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY											
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <u>Maryland</u>			13b. CITY OR TOWN <u>Montgomery</u>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER <u>1310 E. Paulina St.</u>											
14. FATHER'S NAME First <u>HENRY</u> Middle <u>SCHWANZ</u> Last <u>SCHWANZ</u>			15. MOTHER'S MAIDEN NAME First <u>ALMA</u> Middle <u>SCHWANZ</u> Last <u>SCHWANZ</u>																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <u>NO</u>			16b. SOCIAL SECURITY NO. <u>UNKNOWN</u>			17. INFORMANT Address <u>STANLEY C. WASKIEWICZ, 13a, b, c, d, e.</u>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Cerebral Vascular Accidents</u>															<u>1 month</u>					
2381 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Probable Primary Brain Tumor</u>															<u>Same</u>					
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>237X</u>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that <del>the</del> (this hospital) attended the deceased from <u>Sept. 17, 1968</u> , to <u>Sept. 28, 1968</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>Sept. 27, 1968</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did)</del> (did not) view the body after death.																				
22b. SIGNATURE <u>Gene U. Cohen, M.D.</u> DEGREE <u>  </u> ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/>															22c. DATE SIGNED <u>Sept. 28, 1968</u>					
22d. PHYSICIAN'S NAME (Type) <u>GENE U. COHEN, M.D.</u>															22e. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <u>1 OCT. 1968</u>			23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>			23d. LOCATION (City or Town) (County) (State) <u>SILVER SPRING MD.</u>											
24. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME, INC., 7400 GEORGIA AVE. N.W.</u>															25a. REC'D BY REGISTRAR DATE <u>SEP 30 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1950

1950

(M)

(C)

SEP 10 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared 4/20/68 with Dr. John Galt, Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
John W Weber						Sept 20 1968			1 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
male		WHITE		12/12/1894		76 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Russia		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring			Holy Cross			Contractor Retired, Repair			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md			MONT.		Silver Spring		YES		12914 GEISFELD RD
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
NATHAN J. WEBER			UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			579-01-0010		MICHAEL H. WEBER		SAME AS 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Mesenteric Thrombosis, Diabetes mellitus									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4/10/67 to 9/20/68, that (I) (we) last saw the deceased alive on 9/20/68, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE/SIGNED						
John J. Curry, M.D.			9/20/68						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
John J. Curry, M.D.			9801 Georgia Ave Silver Spring						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County)			
Burial		9-22-68		NATIONAL MEM. PARK		FALLS CHURCH		VA	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Sallye Funt Hare			1111 W. W. Ave. DC 20001			SEP 24 1968		Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ration papers, tags, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First ADELE			Middle LOUISE			Last WHITESIDE		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 5-24-1891			2a. DATE OF DEATH Sept. Month 23 Day 1968		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. AGE (In years last birthday) 77 YRS.			2b. HOUR 8:43 P.M.		
9. COUNTY OF DEATH MONTGOMERY			10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) At home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D. C.			13b. COUNTY Washington			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 532--20th Street, N.W.		
14. FATHER'S NAME First Julius			Middle C.			Last Stallmecht			15. MOTHER'S MAIDEN NAME First Katherine		
Middle Schutte			Last Md.			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown			16b. SOCIAL SECURITY NO. 579-34-5794		
17. INFORMANT Mrs. Adele McNaughton, Daughter, Laytonsvill			Address Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Congestive Heart Failure</u> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Recurrent Acute Auricular</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Cerebral Sclerosis</u> Fibrillation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 4 weeks 5-6 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4331											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, etc.) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 1966, to 9/22, 1968, that (I) (we) last saw the deceased alive on 9/22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles E. Woodson, M.D.			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 9/23/68		
22d. PHYSICIAN'S NAME (Type) DR. CHARLES E. WOODSON			22e. ADDRESS 1801 Eye Street, N.W.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 9-26-1968			23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS, INC., D.C. 20016			25a. REC'D BY REGISTRAR DATE SEP 26 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13309

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Mars Lette</i>		First	Middle	Last	2a. DATE OF DEATH Month <i>Sept</i> Day <i>27</i> Year <i>1968</i>		2b. HOUR <i>6:23 AM</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Nov 23 1902</i>		6. AGE (In years last birthday) <i>65</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>Penn</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Sales Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retail</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Germanstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Plummer Rd.</i>	
14. FATHER'S NAME First <i>John</i> Middle <i>Lincoln</i> Last <i>Crandle</i>		15. MOTHER'S MAIDEN NAME First <i>Rose</i> Middle <i>Williams</i> Last <i>Williams</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>113-14-8291</i>		17. INFORMANT <i>June Deming</i> Address <i>Plummer Rd Germanstown</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>2509</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 hours</i> <i>8 yrs</i> <i>18 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>260 X</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>7/1/67</i> , 19 <i>67</i> , to <i>9/27/68</i> , that (I) (we) last saw the deceased alive on <i>9/25/1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert C. Macon</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>9/27/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Robert C. Macon</i>		22e. ADDRESS <i>809 Viers Mill Rd, Rockville, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9-30-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood</i>		23d. LOCATION (City or Town) (County) (State) <i>Waverly Penn</i>			
24. FUNERAL DIRECTOR <i>Ernest G. Gartner</i>		ADDRESS <i>Garthursburg, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 30 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Classified by Dr. John Bull for Dr. Irving Marks to sign*

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First ANNA			Middle ELIZABETH			Last WILLIAMS		
2a. DATE OF DEATH			Month Sept.			Day 28			Year 1968		
2b. HOUR			11 P			M					
3. SEX			Female			4. RACE			White		
5. DATE OF BIRTH			10/3/84			6. AGE (In years last birthday)			83 YRS.		
7a. BIRTHPLACE (State or foreign country)			Wash., D.C.			7b. CITIZEN OF WHAT COUNTRY?			USA		
8. MARRIED			<input type="checkbox"/> NEVER MARRIED			9. COUNTY OF DEATH			Montgomery		
WIDOWED			<input checked="" type="checkbox"/> DIVORCED						Md.		
10. CITY OR TOWN OF DEATH			Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			Holy Cross Hosp.		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			Clerk-Treas. Dept.			12b. KIND OF BUSINESS OR INDUSTRY			Govt.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			Maryland			13b. COUNTY			Montgomery		
13c. CITY OR TOWN			Rockville			13d. INSIDE CITY LIMITS?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER			4811 Eades St.								
14. FATHER'S NAME			First Henry Lawrence			Middle Adams			Last Lowe		
15. MOTHER'S MAIDEN NAME			First Anna			Middle Lowe			Last Lowe		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown)			No			16b. SOCIAL SECURITY NO.					
17. INFORMANT			Sister,			Address			Murray Hawkins, 4811 Eades St. Rkvl. Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident recurrent</i>										Four hours	
4369 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) _____ DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
331X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			HOUR A.M. Month Day Year								
(If either, notify medical examiner)			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/>											
at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from <i>10/2/68</i> , 19 <i>68</i> , to <i>present</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9/17/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>I.L. Marks M.D.</i> DEGREE <i>M.D.</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22c. DATE SIGNED <i>9/29/68</i>											
22d. PHYSICIAN'S NAME (Type)			<i>I.L. MARKS, M.D.</i>			22e. ADDRESS <i>320 University Blvd. East SS Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			10-1-1968			Glenwood Cemetery			Washington, D.C.		
24. FUNERAL DIRECTOR			Joseph Lawler's Sons, Inc.,			ADDRESS			25a. REC'D BY REGISTRAR		
N.W., Wash., D.C., 20016			5130 Wisc.Ave.			DATE			25b. REGISTRAR'S SIGNATURE		
						OCT 2 1968			<i>Charles Judge</i>		

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form F-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
John Edwin Williams						Month Day Year			11:15 M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
M	W.	Jan 8, 1921	47 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year	11:45 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
Arkansas		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Poolesville			Br. 66			Minister			Church
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.			Montgomery			Poolesville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
Edwin			Catherine			Br. 66			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Asphyxia</u>									sudden
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Epileptic seizure</u>									years
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
3533									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
CAUSE OF DEATH			HOUR A.M. P.M.						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
John G. Ball						Sept. 19, 1968			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER						
John G. Ball			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Cremation		9/20/68	Lee's Crematory			Washington, D.C. 20002			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lee Funeral Home			Washington, D.C.			DATE SEP 23 1968		J. Charles Judge	

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18-22a Film 406 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12500 12a & 15 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												13313								
1. DECEASED-NAME (Type or Print) <u>Claude Crenshaw Wilson II</u>						First			Middle			Last			2a. DATE KNOWN OF ESTI-DEATH MATED <u>Sept 11</u> 19 <u>68</u>			2b. HOUR <u>M</u>		
3. SEX <u>M</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>Dec 25 1918</u>		6. AGE (In years last birthday) <u>49</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD <u>Sept 11</u> 19 <u>68</u>			2d. HOUR <u>5:50</u> M					
7a. BIRTHPLACE (State or foreign country) <u>Virginia</u>				7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <u>Montgomery</u> Md								
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>8804 Lanier Dr</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Managerial Clerk</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Montgomery</u>						13b. CITY OR TOWN <u>Silver Spring</u>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>8804 Lanier Dr</u>										
14. FATHER'S NAME First <u>Claude</u> Middle <u>C.</u> Last <u>Wilson I</u>				15. MOTHER'S MAIDEN NAME First <u>Harriet</u> Middle <u>Eaton</u> Last <u>Elizabeth</u>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>yes</u>				16b. SOCIAL SECURITY NO. <u>579-09-4827</u>				17. INFORMANT <u>Maxine Wilson</u> ADDRESS <u>8804 Lanier Drive, Silver Spring, Md</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				
PART I. DEATH WAS CAUSED BY:																				
IMMEDIATE CAUSE (a) <u>428X</u> <u>Acute myocardial disease</u>																				
DUE TO, OR AS A CONSEQUENCE OF																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																				
(b) <u>Chronic myocardial disease</u>																				
DUE TO, OR AS A CONSEQUENCE OF																				
(c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																				
<u>4222</u>																				
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State												
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE <u>John S. Roger</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
EXAMINER'S NAME (Type) <u>John S. Roger, MD.</u>				ADDRESS (Street, city, town, or county)				22b. DATE SIGNED <u>Sept 11, 1968</u>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE <u>9-16-1968</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem</u>				23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>								
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>SEP 16 1968</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>												

13313

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

13301										13314														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR A									
Edna Ethel Wilson										Month Day Year September 12 1968					1:15 M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.									
Female			White			4 November 1911			56 YRS.			MONTHS DAYS HOURS MIN												
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH															
Virginia			USA						Montgomery Md.															
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY									
Bethesda					The Clinical Center, NIH					Postal Clerk					Government									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER								
Maryland					Montgomery					Rockville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			708 W. Montgomery Avenue								
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
Albert Fink					Katie Kapler																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO.					17. INFORMANT														
No					578-20-0964					The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																								
IMMEDIATE CAUSE (a) Intracerebral Hemorrhage															9 hours									
DUE TO, OR AS A CONSEQUENCE OF																								
(b) Ruptured Left Middle Cerebral Artery Aneurysm															9 hours									
DUE TO, OR AS A CONSEQUENCE OF																								
(c)																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
Hypertension and Obesity																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
9/11/68					Ruptured aneurysm					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					Yes									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
					HOUR A.M. Month Day Year P.M. 19																			
21d. INJURY OCCURRED					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION														
White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										Street or R.F.D. No. City or Town County State														
22a. I certify that (X) (this hospital) attended the deceased from Sept. 12, 1968, to Sept. 12, 1968, that (X) (we) last saw the deceased alive on Sept. 12, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE															22c. DATE SIGNED									
Fremont P. Wirth, M.D.															12 September 1968									
22d. PHYSICIAN'S NAME (Type)															22e. ADDRESS									
Fremont P. Wirth, M.D.															The Clinical Center, National Institutes of Health, Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					Sept. 14, 1968					St. Lukes					Redland Mont. Md.									
24. FUNERAL DIRECTOR															25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Francis H. Barber Laytonsville, Md.															DATE SEP 16 1968					f Charles Judge				

MEDICAL CERTIFICATION

13314

13305

Form 10-1008 1-15 Wilson Jones

Virginia 1008 1-15

Virginia 1008 1-15

Virginia 1008 1-15

Virginia 1008 1-15

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13302										13315														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR A									
Lois					Sawyer					Wilson					September 11 1968					1:30 M				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS									
Female			White			7 September 1908			60			MONTHS DAYS			HOURS MIN.									
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH															
Washington			USA						Montgomery Md.															
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY									
Bethesda					The Clinical Center, NIH					Physician					Medicine									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					13e. STREET AND NUMBER				
Washington, D.C.										Washington, D.C.										1121 New Hampshire Ave., NW				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																			
First Middle Last					First Middle Last																			
Thomas					Wilson					Lucy Sawyer														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT														
No					Not Available					Bethesda, Maryland, 20014 The Medical Records, The Clinical Center														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of breast</u> <u>174X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															5 1/2 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
<u>170X</u> <u>Gastric Ulcer</u>																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that <del>the</del> this hospital attended the deceased from <u>5 July</u> , 19 <u>68</u> , to <u>11 Sept.</u> , 19 <u>68</u> , that <del>we</del> (we) last saw the deceased alive on <u>11 September 1968</u> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death.																								
22b. SIGNATURE <u>Gerson N. Kaplan</u> DEGREE										ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED <u>12 September 1968</u>									
22d. PHYSICIAN'S NAME (Type) Gerson N. Kaplan, M.D.										22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
					<u>9-13-68</u>					<u>Lell's Crematory</u>					<u>Tahoga Cemetery</u> <u>Washington State</u>									
24. FUNERAL DIRECTOR										ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
<u>Wilson's Funeral Home</u>										<u>3435-45 St</u>					<u>SEP 13 1968</u>					<u>Charles Judge</u>				

MEDICAL CERTIFICATION



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CERTIFICATE OF DEATH

13316

1. DECEASED-NAME (Type or print) <i>MARY</i> First Middle <i>CRANAGE</i> Last <i>WING</i>			2a. DATE OF DEATH Month <i>Sept.</i> Day <i>23</i> Year <i>1968</i>			2b. HOUR <i>1:45 AM</i>	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>11/10/10</i>		6. AGE (In years last birthday) <i>57</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Sherborn Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>ECONOMIST</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>FEDERAL RESERVE</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>D.C.</i>		13b. COUNTY <i>Wash D.C.</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2426 CONN. AVE. N.W.</i>	
14. FATHER'S NAME First Middle Last <i>Narcis L. Wing</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Blanche Mumford</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No.</i>		16b. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Dr. Wilson D. Wing</i> Address <i>905 1st St. N.W.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Liver Insufficiency</i> <i>571.0</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cirrhosis of Liver (Laennec's Type)</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>two weeks</i> <i>year</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>5811</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>9-14</i> , 19 <i>68</i> , to <i>9-23</i> , 19 <i>68</i> , that (I) (we) lost the deceased alive on <i>9-22</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Earl H Mitchell</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>9-23-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>EARL H MITCHELL</i>		22e. ADDRESS <i>2029 Q ST N.W.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>9/24/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, 5130 Wis., Ave. Wash. D.C.</i>				25a. REC'D BY REGISTRAR <i>SEP 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13816

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card and return it to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13304  
CERTIFICATE OF DEATH  
13317

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>11918 Oakwood Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>ChA L. WOOD</u>				4. DATE OF DEATH Month Day Year <u>Sept 9 19 68</u>					
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 4. 1884</u> 84 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>GA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. Field</u>				14. MOTHER'S MAIDEN NAME <u>UNK - Nichols</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>331X</u>		17. INFORMANT Address <u>Mrs. Norma Farula #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA (cerebral artery insufficiency)</u> <u>4379</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>331X Acute Coronary Thrombosis (onset Sept 2 1968)</u>								INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>Unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (his hospital) attended the deceased from <u>July 22 1968</u> to <u>September 9 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 5 1968</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.								22b. DATE SIGNED <u>Sept 9, 1968</u>	
22a. SIGNATURE <u>Arnon H. Traum</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <u>ARNON H. TRAUM</u> M.D.				22d. ADDRESS <u>1237 Georgia Ave. Silver Spring, Maryland</u>					
23a. BURIAL CREMATION REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Sept 9, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>Landover, Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Callender</u> 3603 18th St NW Wash DC 20010				25a. REC'D BY REGISTRAR <u>SEP 13 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

2122

6080



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13306

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13319

1. DECEASED-NAME (Type or Print) <b>OSCAR</b>			First Middle Last <b>YEDLIN</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>9</b> Day <b>6</b> Year <b>1968</b>			2b. HOUR <b>8:23 PM</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>1896</b>	6. AGE (In years last birthday) <b>72</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>		2c. DATE PRONOUNCED DEAD Month <b>Sept.</b> Day <b>6</b> Year <b>1968</b>			2d. HOUR <b>8:23 PM</b>	
7a. BIRTHPLACE (State or foreign country) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Russia</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.						
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Tailor</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Hyatts.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8239 14th Ave.</b>		
14. FATHER'S NAME <b>Pinhas</b>			First Middle Last <b>Yedlin</b>			15. MOTHER'S MAIDEN NAME <b>Rebecca</b>			First Middle Last <b>Finkelstein</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Son,</b>			ADDRESS <b>Joseph Yedlin 1412 Univ. Blvd. Hyatts., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4200</b>												
19a. DATE OF OPERATION <b></b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b></b>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b></b> P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b></b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b></b>			21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>9/6/1968</b>			
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street city, town, or county) <b></b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>9/8/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Hyattsville, Md.</b>				
24. FUNERAL DIRECTOR <b>B. Babin</b>						ADDRESS <b>501 - 14 St N.W. Wash. D.C.</b>			25a. REC'D BY REGISTRAR <b>SEP 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

255

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-64)  
30M REV. 1-64

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
13307					13320												
1. DECEASED-NAME (Type or print)					First		Middle		Last		2a. DATE OF DEATH			2b. HOUR			
DAVID					YOUNG		Sr.		SEPT 19 1968			9:30 PM					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS						
MALE		NEGRO		3-8-1880			88 YRS.		MONTHS DAYS		HOURS MIN						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.							
VIRGINIA		U.S.A.				MONTGOMERY											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY											
ROCKVILLE		408 McLEAN CT		RETIRED		NONE											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER									
MD		MONTG.		ROCK.				408 McLEAN CT.									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
GEORGE		YOUNG						MARTHA		WASHINGTON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address											
NO				MRS MOLLIE MERCER		408 McLEAN CT. ROCKVILLE											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subacute Myocardial Infarction</u> 185X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cholelithiasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Distal to the Coronary Arteries of the Heart</u> 420 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 177X <u>None</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 18 1967</u> to <u>Sept 19 1968</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Sept 18 1968</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.										22b. SIGNATURE <u>John S. Rogers</u>		22c. DATE SIGNED <u>Sept 19 1968</u>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS		22g. ADDRESS		22h. ADDRESS									
JOHN S. ROGERS M.D.		1919 SEMINARY RD, SILVER SPRING, MD															
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)											
BURIAL		9-23-68		CARVER MEMORIAL PARK		LAUREL, PR. GRG MD											
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
ROBERT L. SNOWDEN		ROCKVILLE, MARYLAND		DATE SEP 25 1968		<u>Charles Judge</u>											

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ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10-10-2001 BY 60322  
UCBAW/BJS/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>MAUDE</b>			First Middle Last <b>YOUNG</b>			2a. DATE OF DEATH Month <b>SEPT</b> Day <b>18</b> Year <b>1968</b>			2b. HOUR <b>3:15 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MARCH 29, 1878</b>			6. AGE (In years lost birthday) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.				
10. CITY OR TOWN OF DEATH <b>KENSINGTON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL HALL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gov. - Army</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b>			13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>WASHINGTON</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>3717 JOCELYN ST. N.W.</b>	
14. FATHER'S NAME First <b>N. A.</b> Middle <b>N. A.</b> Last <b>N. A.</b>			15. MOTHER'S MAIDEN NAME First <b>ELIZABETH</b> Middle <b>SAUNDERS</b> Last <b>SAUNDERS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>N.A.</b>		17. INFORMANT Name <b>Mary, Crookshank Perry Home</b> Address <b>Ref.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4129</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Due to, or as a consequence of</b> (b) <b>arteriosclerosis and</b> <b>Due to, or as a consequence of</b> (c) <b>arteriosclerotic heart disease</b> <b>1 + cpr.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days.</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>332X</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR <b>19</b> A.M. <b>19</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b>522 WESTERN AVE</b> City or Town <b>WASHINGTON</b> County <b>D.C.</b> State <b>D.C.</b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>16 SEPT 1968</b> to <b>18 SEPT 1968</b> , that (I) (we) last saw the deceased alive on <b>16 SEPT 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>A. H. Richwine, MD</b>		22c. ADDRESS <b>522 WESTERN AVE</b>		22d. ADDRESS <b>CHEY CHASE, MD.</b>		22e. DATE SIGNED <b>18 SEPT 1968</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>9-20-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 23 1968</b>		
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		ADDRESS <b>5130 Wisc. Ave.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>						



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18381

UNITED STATES OF AMERICA

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SEP 2 1968

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

13309

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13322

1. DECEASED-NAME (Type or Print) <b>YOURKE LOUBIEN YOURKE</b>			20. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> <b>Sept 13</b> 1968 <b>5:45 AM</b>			2b. HOUR <b>5:45 AM</b>			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>Sept 29, 1898</b>	6. AGE (In years last birthday) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD <b>Sept 13</b> 1968 <b>6 AM</b>			
7a. BIRTHPLACE (State or foreign country) <b>Rumia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Quince-Ballet Art School</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMP.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>1360 Maryland</b>				13b. CITY OR TOWN <b>Bethesda</b>	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>7111-44th St.</b>			
14. FATHER'S NAME First <b>LUBIEN</b> Middle <b></b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle <b></b> Last <b></b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>130-09-5878</b>		17. INFORMANT ADDRESS <b>Elizabeth Yourke - wife - add. same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Coronary Insufficiency Acute.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>cardiovascular Disease.</b> (b) <b>years.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John G. Ball</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>Sept 13, 1968</b>			
EXAMINER'S NAME (Type) <b>JOHN G. BALL</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) <b>MONTG. COUNTY, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>9/16/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>DOUG GAWLER'S SONS</b>				ADDRESS <b>5130 WISCONSIN AVE., N.W., DC</b>		25a. REC'D BY REGISTRAR <b>SEP 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13310

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <b>John G. Zieler</b>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>10:00</b> AM		
3. SEX <b>M.</b>	4. RACE <b>W.</b>	5. DATE OF BIRTH <b>June 1, 1913</b>	6. AGE (In years last birthday) <b>55</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>Sept.</b> Day <b>21</b> Year <b>1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>228 Granville Drive</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Finance Officer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gov. Hous.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>228 Granville Drive.</b>			14. FATHER'S NAME First <b>John David</b> Middle <b>Zieler</b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>Alice</b> Middle <b>A.</b> Last <b>Rowles</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO. <b>216-44-4539</b>		17. INFORMANT ADDRESS <b>Francis Mary Zieler wife</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Coronary Insufficiency Acute</b> DUE TO, OR AS A CONSEQUENCE OF <b>Cardio Vascular Disease.</b> (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF <b></b> (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden.</b> <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>								
19a. DATE OF OPERATION <b>4201</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County
State		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <b>John G. Ball</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>Sept. 21, 1968</b>		
EXAMINER'S NAME (Type) <b>John G. Ball</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county)			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Sept. 25, 1968</b>					
23b. DATE			23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek</b>			23d. LOCATION (City or Town) <b>Washington, DC</b> (County) (State)		
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc. 8434 Georgia Ave.</b>			25a. REC'D BY REGISTRAR <b>SEP 25 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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